the MODERN HOSPITAL

VOLUME 63 JULY 1944 NUMBER 1


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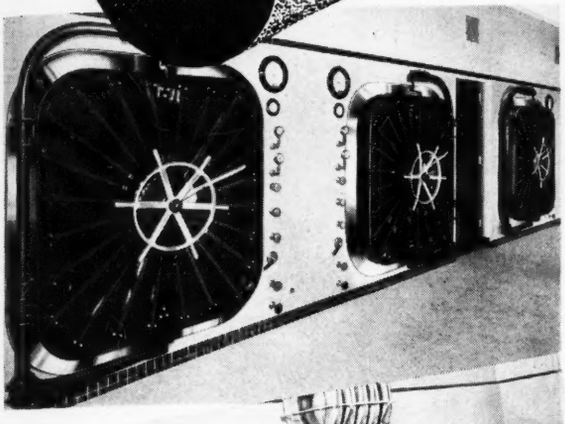

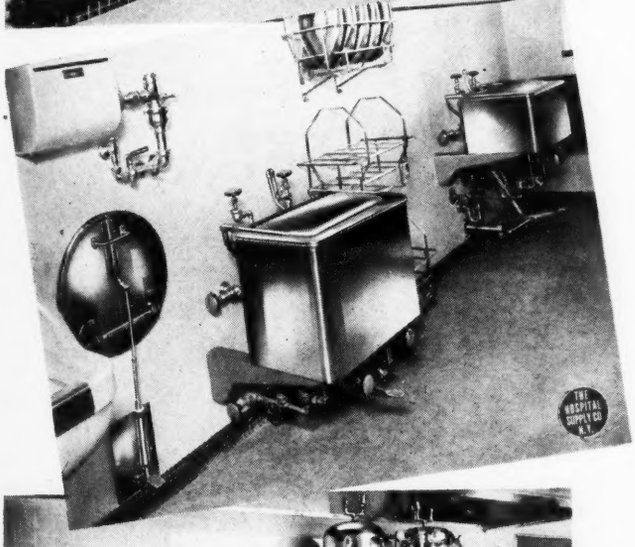

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CONTENTS

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THE ROVING REPORTER

For Safe Keeping

A personal professional library within the hospital's professional library, that's what those blond wood cabinets at one end of the interns' reading room at Provident Hospital, Chicago, signify.

Provident's director of housekeeping, Mrs. Mary Blount Anderson, contributed this idea to the design when a new one story interns' building was recently erected. The young doctors who compose the house staff of the hospital needed a safe place to keep their expensive professional books, the stethoscopes they received at graduation and other personal possessions that just might prove a temptation to someone if left in their own bedrooms, Mrs. Anderson decided.

So attractive wooden lockers were built in on one library wall and each intern now has his individual locker for books. The lockers have a shelf inside.

Provident Hospital is the only all-Negro institution approved for resident study in surgery. This, along with its affiliation in medicine with the University of Chicago and its huge clinic (second in size only to that of Cook County Hospital in the Chicago area), enables it to attract an able group of interns and residents.

Pain Bought Off

Recently, a former patient came to the cashier's window at Rochester General Hospital, Rochester, N. Y., and inquired about a bill incurred back in early depression days when she had suffered an injury to her arm.

A long search revealed the amount of the bill and when the former patient had been given her receipt, she confidently spoke: "Now I know my arm won't hurt me. The folks at home told me that if I came here and paid this old bill my arm wouldn't pain me any more."

Help From a Hobby

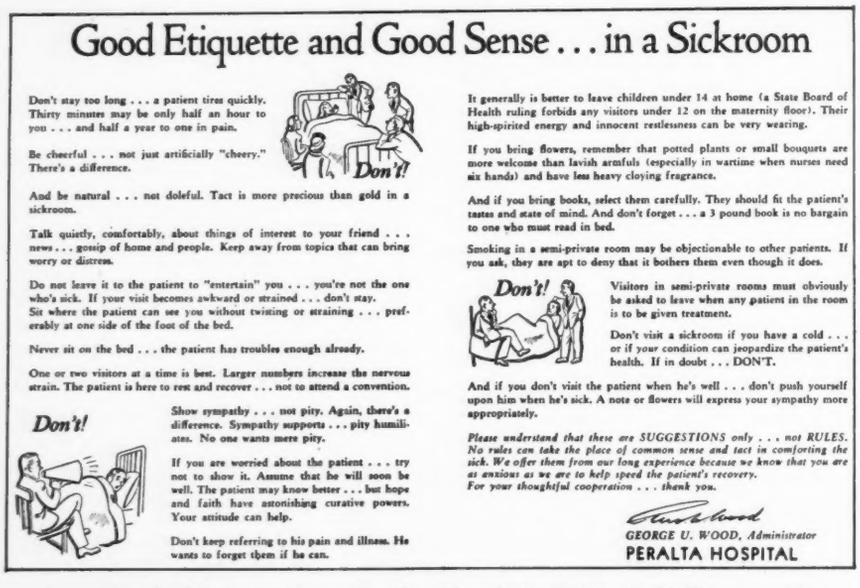
Here's an idea that is not patented and is bringing in treasure. It originated at St. Luke's Hospital, Chicago. We quote from the *St. Luke's News* for May:

"Ever get tired of being in a rut and decide to develop an outside interest? Did you take lessons? Then buy the equipment? Remember how you had a room cleared out and set up the loom or the wood carving set or collected old ties to make rugs?

"How long did the hobby last? It probably kept you pretty busy for quite a while until Mr. Hitler found other ways to take care of our spare time. But the thing St. Luke's wants to know is this: What did you do with all the equipment?"

Then the story takes a wistful turn. Such materials can't be bought nowadays and St. Luke's occupational therapy department could use that stuff that is packed away in the attic or basement or spare closet. It would mean a lot in the rehabilitation of patients, the appeal says.

Particularly needed are jigsaw or electric lathes, sewing machines, woodworking tools and looms, but almost any



Good Etiquette and Good Sense . . . in a Sickroom

Don't stay too long . . . a patient tires quickly. Thirty minutes may be only half an hour to you . . . and half a year to one in pain.

Be cheerful . . . not just artificially "cheery." There's a difference.

And be natural . . . not doleful. Tact is more precious than gold in a sickroom.

Talk quietly, comfortably, about things of interest to your friend . . . news . . . gossip of home and people. Keep away from topics that can bring worry or distress.

Do not leave it to the patient to "entertain" you . . . you're not the one who's sick. If your visit becomes awkward or strained . . . don't stay. Sit where the patient can see you without twisting or straining . . . preferably at one side of the foot of the bed.

Never sit on the bed . . . the patient has troubles enough already.

One or two visitors at a time is best. Larger numbers increase the nervous strain. The patient is here to rest and recover . . . not to attend a convention.

Don't!

Show sympathy . . . not pity. Again, there's a difference. Sympathy supports . . . pity humiliates. No one wants mere pity.

If you are worried about the patient . . . try not to show it. Assume that he will soon be well. The patient may know better . . . but hope and faith have astonishing curative powers. Your attitude can help.

Don't keep referring to his pain and illness. He wants to forget them if he can.

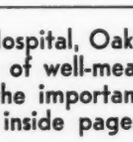
It generally is better to leave children under 14 at home (a State Board of Health ruling forbids any visitors under 12 on the maternity floor). Their high-spirited energy and innocent restlessness can be very wearing.

If you bring flowers, remember that potted plants or small bouquets are more welcome than lavish armfuls (especially in wartime when nurses need six hands) and have less heavy cloying fragrance.

And if you bring books, select them carefully. They should fit the patient's tastes and state of mind. And don't forget . . . a 3 pound book is no bargain to one who must read in bed.

Smoking in a semi-private room may be objectionable to other patients. If you ask, they are apt to deny that it bothers them even though it does.

Don't!



Visitors in semi-private rooms must obviously be asked to leave when any patient in the room is to be given treatment.

Don't visit a sickroom if you have a cold . . . or if your condition can jeopardize the patient's health. If in doubt . . . DON'T.

And if you don't visit the patient when he's well . . . don't push yourself upon him when he's sick. A note or flowers will express your sympathy more appropriately.

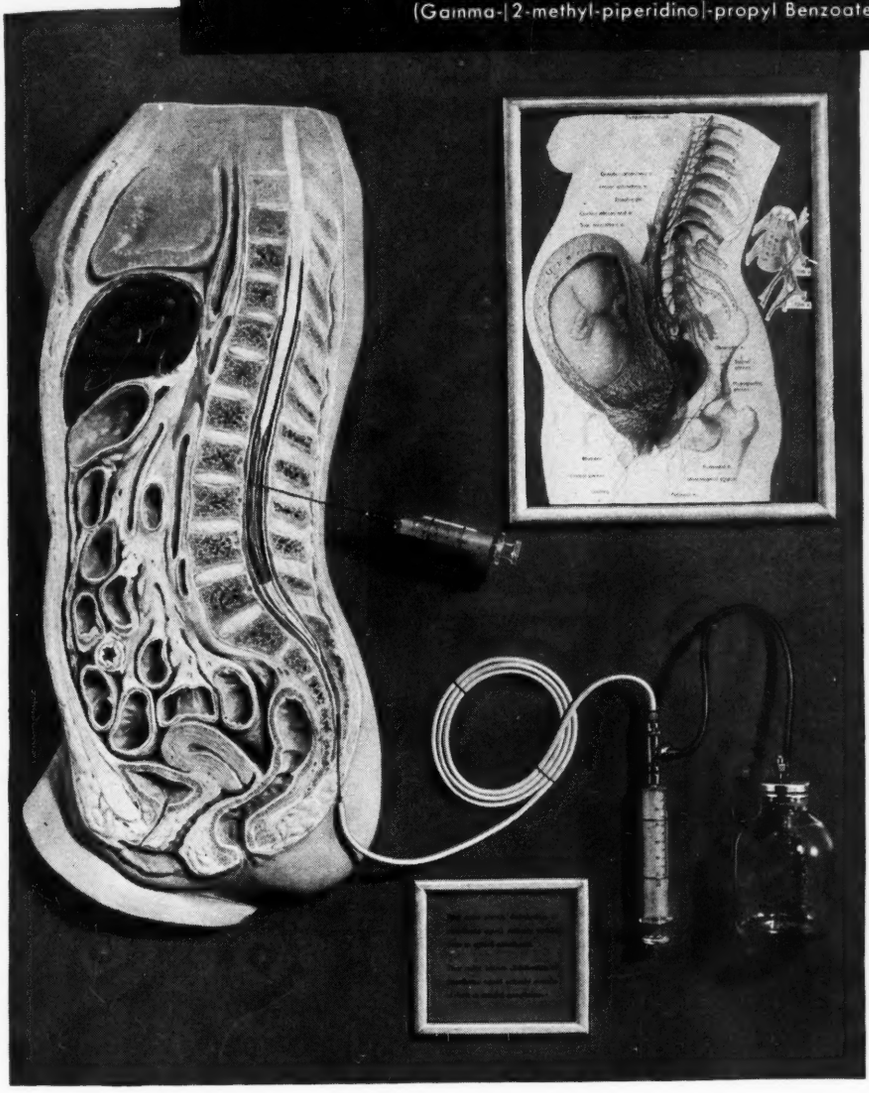
Please understand that these are SUGGESTIONS only . . . not RULES. No rules can take the place of common sense and tact in comforting the sick. We offer them from our long experience because we know that you are as anxious as we are to help speed the patient's recovery. For your thoughtful cooperation . . . thank you.

GEORGE U. WOOD, Administrator
PERALTA HOSPITAL

A practical plea to visitors. Peralta Hospital, Oakland, Calif., uses this attractive folder to call the attention of well-meaning but thoughtless friends and relatives of patients to the importance of good bedside manners. Shown above are the two inside pages of the leaflet.

METYCAINE

(Gamma-[2-methyl-piperidino]-propyl Benzoate Hydrochloride, Lilly)



The difference between caudal and spinal anesthesia is clearly demonstrated in the accompanying illustration, which is a reproduction of a panel in the state medical association exhibits for 1944.

Lilly

'METYCAINE' (Gamma-[2-methyl-piperidino]-propyl Benzoate Hydrochloride, Lilly) is a local anesthetic agent useful not only for spinal and caudal anesthesia, but also for other forms of regional anesthesia, local infiltration, and topical application to mucous membranes. 'Metycaine' is about one-third more potent than procaine, permitting an average reduction in concentration of one-fourth. 'Metycaine' has a quicker yet more prolonged action, is more certain in its effect, and is clinically no more toxic. Individuals who are hypersensitive to procaine will tolerate 'Metycaine.'

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type of handicraft apparatus is acceptable.

Probably your local newspaper would carry a similar story if your hospital is actually in need of such equipment.

More Britons Help Grasslands

Do you remember the story that appeared in these columns recently about members of a British hospital unit who signed away three weeks of shore leave to lend their services to Grasslands Hospital, Valhalla, N. Y.? A sequel has been written lately which Dr. E. L. Harmon, director, reviews.

"Our British friends are with us again, in larger force than ever. In addition to a return visit from Commander Durand's unit, we also have had six men from the Royal Army Medical Corps assigned to another permanent hospital unit in a large British ship. The smaller group will be with us for approximately five weeks and Commander Durand's unit, comprising this time in addition to himself and his chief nurse, Sister Barnes, 20 enlisted men instead of 16, for a period of approximately two weeks.

"Of the 20 enlisted men, 14 are repeaters; the other two who were with us before have been transferred to another assignment and are no longer with Commander Durand. They have all started in where they left off in their former assignments working on a full daily schedule along with our paid employes."

What better example can there be of a good neighbor policy?

Famous Laboratory

When a year or so ago a low-priced hearing aid came upon the market, its potential reliability was not doubted by Abington Memorial Hospital's Otological Research Laboratory. The reason is that many persons in and around Abington, Pa., had been wearing hearing aids built in the hospital's laboratory at a cost of $19.

The Otological Research Laboratory had for some time been supplying these hearing aids to clinic patients certified by the hospital's social service department. The only requirement for getting such an aid to hearing was that, when the patient had become sufficiently rehabilitated to hold down a job and save enough to purchase a commercially made hearing aid, he would return the laboratory's instrument. If he had paid small amounts on the hospital's hearing aid, these payments were refunded to him when he turned in the equipment.

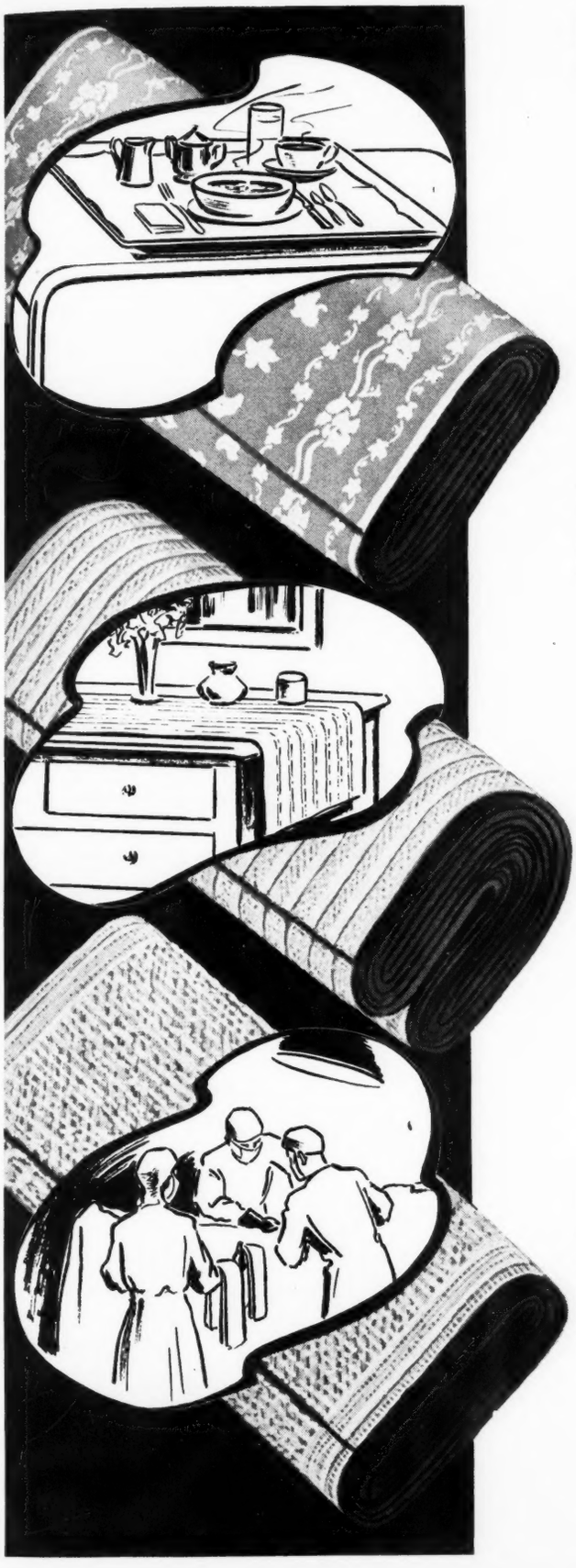
One of this laboratory's chief jobs is to fit hearing aids scientifically, it having been established in a recent survey that 80 per cent of hard of hearing persons are completely satisfied when their instrument is scientifically fitted at purchase, while only 60 per cent find complete satisfaction without such a fitting.

The hospital takes pride in the fact that the American Academy of Ophthalmology and Otolaryngology is to use in its nation-wide program the manual for the rehabilitation of military and civilian aural casualties of the war prepared by research workers in this otological laboratory. It was natural that this manual should be developed at Abington since Dr. Walter Hughson, director, and his laboratory staff serve in an advisory capacity to the surgeon generals' offices of the Army and Navy.

Last December the laboratory sponsored an instructional course for 40 otologists in the state. It is now working with the Philadelphia board of education in training public health nurses in the technic of making hearing tests on school children.

Recently there has been a tremendous increase in the number of school children referred to the clinic from Philadelphia, adjacent counties and from Delaware and New Jersey.

In addition to the activities described the Otological Laboratory is constantly conducting experiments in clinical research in the field of human deafness and aural disorders.



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SHEETS	CURTAINS	PIECE GOODS

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READER OPINION

Let's See What Happens

Sirs:

Purchasing reprints of the Trustee Forum for distribution among our trustees strikes me as a very good way to bring hospital problems to the attention of board members. You can, therefore, put us down for 20 copies for six months and we shall see what happens.

Van C. Adams
Superintendent

The Jewish Hospital
Cincinnati

Endless as Eternity

Sirs:

When I returned to Atlantic from the Iowa Hospital Association convention, I found that the laboratory technician had left while I was in Des Moines. The week before when I was in Kansas City, the dishwasher left to work in a hamburger stand near a defense plant in Des Moines. And so it goes—as endless as eternity, I am afraid.

Since I am the only other graduate laboratory technician in the community, I have been adding those duties to the numerous and varied others that befall the administrator of a small hospital. Truly, I believe that anyone aspiring to be a hospital administrator should serve an internship in a small hospital. You have to be able to replace anyone from the janitor to the nurse in the birth room, and not infrequently simultaneously.

Lilyan C. Zindell
Administrator

Atlantic Hospital
Atlantic, Iowa

It's Suburban Hospital

Sirs:

Just where did you get the picture of the "Arlington" nursery that appears on page 4 of May MODERN HOSPITAL? It so happens that this is a picture of the Suburban Hospital nursery and the young lady at the bassinet is our Miss Dorsey.

Shame on you!

J. Dewey Lutes
Superintendent

Suburban Hospital
Bethesda, Md.

Favorable Reactions

Sirs:

I have mailed a copy of Trustee Reprints to each member of the board and have had very favorable reactions.

Personally, I am of the opinion that Mr. Fitzgerald knows what he is talking about (March issue, p. 84) and I believe articles of this kind are a great aid to the administrator in helping him to give the members of his board an appreciation of their responsibility and of the work in the entire hospital field.

F. C. Leupold
Superintendent

Jamaica Hospital
Jamaica, Long Island, N. Y.

"Peace"

(The following is an excerpt from a letter received by a New York hospital administrator.)

Sirs:

I have your acknowledgments of the acts of restitution made by two of MY followers, and I appreciate knowing that they have realized and made right their wrong in taking food that was not directly for them.

Selfish gain has been so predominant in the minds of the people that even to those who have been changed in nature and characteristics, those sly foxes cause them to overlook the apparent insignificant things at times; yet, MY true followers would not so much as take a little brass pin and use it for himself, or steal a minute's time from their employer that was not due them.

The daily habits of the people who are being born into the Immaculate Conception of the Christ are expressing the reality of the Kingdom Christ prayed for, and it will not be long before the honesty, competence and truth depicted in the lives of millions following ME will be practiced by the masses. . . .

This is indeed a new era of economic righteousness and I believe the whole world can see in the honest activities of MY followers, the reality of that long sought for Utopian Government, where men and governments live and thrive in being just, according to one of the greatest maxims of Christ:

"Do unto others, as you would that men should do to you."

Respectfully and Sincere, I am
Rev. M. J. Divine
(Better known as FATHER DIVINE)

(Note: The following communicants of Father Divine's church are in the employ of the hospital:

Miss Wonderful Love
Miss Love One
Miss Wonderful Joy
Miss Peace Victory
Miss Sweetness Love Victory
Miss Queen Esther
Miss Joy Smiles)

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Flammable Liquids and Gases

Question: Is there a term that can be used to refer generically to alcohol, ether, ethylene and other such substances which, when mixed with air or oxygen, may form explosive mixtures? If they cannot be called explosives, what should they be called?—J.B., Ill.

ANSWER: One should not use a single term to include alcohol and ether, which are liquids, and ethylene, which is a gas.

The general terminology in fire prevention work has been to group the hazardous liquids of this character as flammable liquids—witness the committee on flammable liquids of the National Fire Protection Association.

Gases that form hazardous mixtures with air or oxygen should be referred to as flammable gases although some people term them combustible gases. Underwriters' Laboratories' practice is to use the former term.—J. I. BANASH.

Combined Jobs

Question: In a 28 bed hospital do you think it advisable to have a nurse capable of both administering anesthetics and acting as assistant to the superintendent? What should her salary be?—A.P., Minn.

ANSWER: The combination of a nurse anesthetist and assistant to the superintendent in a small hospital would be very satisfactory. To obtain a person with the proper training and experience, her salary should be at least $200 a month, plus maintenance.—WILLIAM J. DONNELLY.

Spinal Anesthesia Setup

Question: Will you please describe the preparation, treatment and technic used in spinal anesthesia and also give a list of drugs and needles.—N.K., Mich.

ANSWER: A full discussion of preparation, treatment and technic is contained in a bulletin entitled "Spinal Anesthesia" by Janet McMahon reprinted from the *Bulletin of the American Association of Nurse Anesthetists,* November 1943.

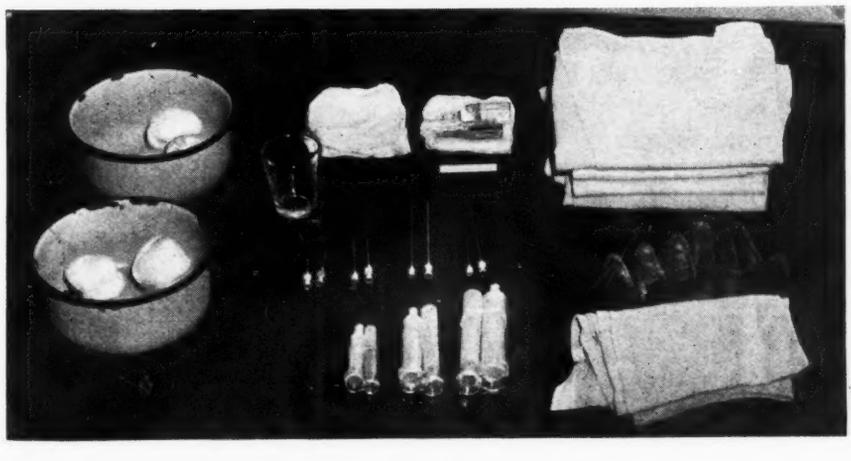
The picture shows the setup of the spinal table, on which are placed the following:

1 Medicine glass
1 File
1—10 cc. Luer-loc syringe
1— 5 cc. Luer-loc syringe
1— 2 cc. Luer-loc syringe
Needles:
1—2 by 22
1—¾ by 25 Pitkin
1—3½ by 18 Spinal
2—3½ by 20 Spinal
6—Scrub sponges
4—7's

If the surgeon prefers gold needles, we substitute gold spinal needles for the regular needles, putting on the tray: 1—3 by 20 and 2—3 by 19.

Most of our surgeons use pontocaine, and if they do we place on the tray: 1 ampule of pontocaine and 1 ampule of 10 per cent dextrose. The pontocaine is weighted with the dextrose.

We also put on the tray one 1 cc. ampule containing procaine hydrochloride 1 per cent and ephedrine grain ¾. Of course, some of our men use spinocaine or novocaine crystals.—MRS. GERTRUDE L. FIFE.



Pay for Graduates

Question: How much should a graduate nurse be paid when she works by the hour only? I was told that most hospitals pay $1 for the first hour and 50 cents for each succeeding hour. Does that seem correct?—Sr. M.G., Minn.

ANSWER: In some hospitals in the metropolitan area, graduates are paid 75 cents an hour when working part time and receive whatever meals happen to come during their period of service. That would be the equivalent of $6 for eight hours or $7 if two meals are included. Hourly visiting nurses from the registry of the first district, Illinois State Nurses' Association, are paid $2 for the first hour or fraction and 50 cents for each additional half hour, or a maximum of $4 for four hours.—ELIZABETH ODELL.

Time Off for Interns

Question: In a 100 bed hospital in which an anesthetist and four interns are engaged, how much time off should be given the interns? The anesthetist?—N.E.Y., N. Y.

ANSWER: Many hospitals would like to be faced with the problem posed in the foregoing question. The 100 bed hospital fortunate enough to have an anesthetist and four interns should be able to give them alternate nights off duty, from 5 p.m. to 7 a.m., and alternate week ends, from 12 noon on Saturday until 7 a.m. on Monday.

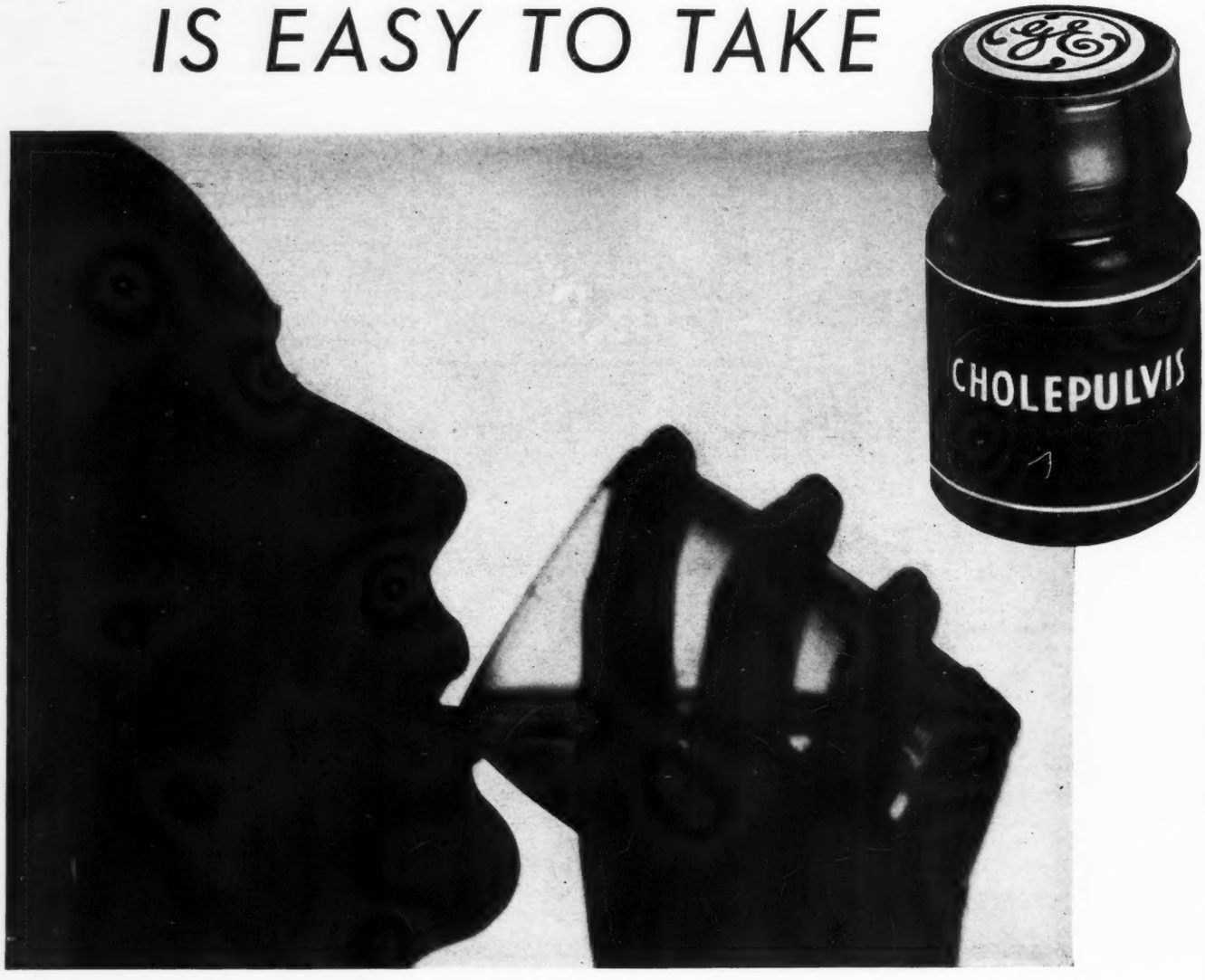
The interns could be trained to administer a satisfactory anesthetic for the emergency operations occurring while the trained anesthetist was off duty.—WILLIAM J. DONNELLY.

Checking Patients' Trays

Question: What is the supervisor's duty in a small hospital in regard to preparing and checking food trays, special diets and food brought by patients' friends?—Sr. B., Sask., Can.

ANSWER: In the event that the small hospital is fortunate enough to have the services of a competent registered dietitian, the only time that the supervisor could be held responsible for a check of the food trays as to special diets or food brought by visitors would be on the dietitian's day off or during the period when she was on vacation. In the event that there is no dietitian in attendance, it then becomes the duty of the supervisor or head nurse or someone else with a knowledge of diets to accept the responsibility for the preparation of the food for special diets and food brought by patients' friends. In times like these it is believed best to discourage food being brought into the patient by relatives.—A. A. AITA.

CHOLEPULVIS
IS EASY TO TAKE



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LOOKING FORWARD

Industry Leads the Way

SINCE the pioneer work of Dr. Alice Hamilton, commenced in 1910, industrial medicine and hygiene has made tremendous strides in protecting the health of the industrial worker. Under the influence of the new knowledge gained, laws have been enacted and industrial plants have been prevailed upon to ameliorate working conditions and to inaugurate safeguards against industrial health hazards. To this end also our industrial plants, one after another, established their medical departments. Preemployment and preplacement examinations have been introduced and these have become more comprehensive as time goes on.

In 1937 the National Association of Manufacturers established its Committee on Healthful Working Conditions which "has been engaged in collecting and disseminating information on health and working conditions in industry in an effort to reduce the tremendous toll of time and money taken by illness and accidents."

The report of this committee, published in October 1941, states among other items that (1) about 80 per cent of 2064 plants surveyed utilize preemployment examinations and about 50 per cent give periodic physical examinations; (2) about 40 per cent have introduced health education of employes to prevent ordinary illnesses; (3) 43 per cent of the plants reporting had established their health services during the depression decade; (4) 70 per cent of the programs instituted within the last five years were in plants having fewer than 500 employes. It was estimated that "a health program saves the average 500 employe plant $5611 net per year."

Hospital administrators point with pride to the fact that American hospitals in the aggregate constitute the sixth largest industry of the country. Furthermore, hospitals serve the health of the nation and are becoming more and more the health centers of their respective communities. But are they rendering as extensive a service to the health protection of their own employes as do our industrial plants?

In this connection it must be remembered that for the establishment of their health services the industrial plants had to organize special departments with special personnel and equipment. In hospitals, the personnel and equipment are already available and an adequate program calls for no special expenditures. Yet how many hospitals utilize regular preemployment examinations or have a tuberculosis prevention program as do many of our industries?

In 1939 the Council on Professional Practice of the American Hospital Association issued its report on the management of tuberculosis in general hospitals, which includes some excellent advice on tuberculosis prevention among the personnel. This fine publication collects dust on the shelves of most hospital administrators, if it can even be found there. The hospitals that have adopted the practices advocated are few and far between. And yet, tuberculosis must be considered as an industrial hazard as far as hospital people are concerned.

In personnel practices hospitals are starting to follow the lead of industry. Strange as it may seem, it is time that they do so in regard to health protection measures. Hospital hygiene should play just as important a part in hospital administration as does industrial hygiene in industrial management.

A special committee appointed by the American Hospital Association to publicize the report of the Council on Professional Practice and to urge hospitals to observe its injunctions could render yeoman service to administrators, hospitals and hospital workers in general.

Postwar Medicine

RECENTLY a major in the Army Medical Corps wrote from North Africa to the editor of *Medical Care* concerning the discussion among medical officers of the conditions of practice after the war. "Nearly all the medical officers express the opinion that fundamental changes will take place in medical practice after the war," he stated. "There is an amazing variety of opinion and much of it is bizarre. . . . One is conscious of two developments.

"First, soldiers and nonmedical officers expect and are getting excellent medical care. The rank and file are seen promptly by their field medical officer for the slightest complaint and transfer to hospitals, when indi-

cated, is effected quickly. Within the hospitals patients see excellent equipment and get prompt expert consultations; an early decision and disposition are made on each case. Their problems are investigated thoroughly and a decision is reached by a board that surveys the findings. After the war this large group of people will judge future medical care from this experience in smoothly functioning group medicine.

"Second, the medical officers themselves will look back with appreciation (even if they deny it) to their Army days when they could freely call in consultants and use all the technical facilities at the command of the hospital to the solution of a particular clinical problem without worrying about the expense to the patient. Their attitude regarding the broad features of medical care is undergoing a change and will unquestionably be reflected in civilian practice on their return home."

There is a growing understanding in the United States of the economy and efficiency of properly organized group practice. Some difficulties, of course, are encountered in any group practice organization. But, with proper leadership and intelligence, they can be overcome.

The important new element in the situation is that there is constantly increasing appreciation of the fact that group practice should be organized around and in intimate cooperation with voluntary hospitals. This does not inhibit or jeopardize the physician's opportunity to practice medicine. Quite the contrary; it releases his energies from economic constraints so that he can practice more and better medicine.

Hospital administrators and trustees should be giving serious thought to this problem now. Those who wish to know about the experiences of other hospitals can read with profit the following articles in The MODERN HOSPITAL: "Group Practice Is One Answer" by Bowler and Sycamore (May 1944, p. 46); "Group Medicine Works Here" by Wilson (April 1942, p. 73); "At Home in a Texas Hospital" by Sloan (October 1939, p. 52); "Group Practice Succeeds in Rural Community" by Sexton (April 1935, p. 41); "The Quality of Care Rendered by Group Clinics" by Bay (January 1934, p. 83); "Group Practice and the Rôle of the Family Doctor" by Pino (July 1933, p. 79) and "Providing Annual Medical Service in Private Group Clinics" by Rorem (January 1932, p. 75).

Length of Nursing Education

IF THE war has done nothing else, it has shown many of us valuable new technics. Some of the most valuable are in the field of education, where jobs are now being done in much less time than formerly. In a recent address, William R. Spreigel of the department of management of Northwestern University pointed out that through new educational methods it is now possible adequately to train a tool and die maker, the king of mechanics, in two years instead of four. He challenged hospitals to restudy the education of nurses because he felt convinced that somewhat comparable results could be obtained.

A nurse hospital administrator recently was bemoaning the large amount of needless repetition and wasted time in the nurse's education. When we stop to consider the information and knowledge that a nurse's aide acquires in an eighty hour Red Cross course, we realize that this represents a challenge to nursing education. Before we decide to extend nursing education again to its former length, it would be well to consider carefully the lessons of the war. Perhaps a restudy of our teaching methods and curriculum construction may show that from twenty-four to thirty months is sufficient.

Pay for Care of Indigents

USING the material published in The MODERN HOSPITAL on the desirability of paying adequate amounts for the care of the indigent, the hospital administrators of Auburn, N. Y., called a meeting of welfare officials of the area. After discussion of the problem and a summary of the articles on "Poor Laws or Public Welfare" in our March issue, the welfare officials agreed unanimously to raise the rate of payment to the voluntary hospitals to $5.25 per day as an inclusive rate for all welfare cases.

It is a pleasure to see our campaign for adequate payment for indigent care being taken up vigorously by local hospital administrators. In this way they can help to undergird the financial position of the hospital, if a recession or depression should occur after the war.

Aid for Coordination

THE Commonwealth Fund announced recently a new program under which it would undertake to aid with subsidies an experiment in the regional organization of hospital service. Readers of The MODERN HOSPITAL will quickly recognize that this is one of the subjects advocated in this journal.

The Fund states that its eighteen years' experience in the rural hospital field has pointed to the need of some form of organization whereby the services of consultants naturally concentrated in the cities and medical centers will be made available throughout a region.

The experiences of the Bingham Associates in Maine and of the Kellogg Foundation in Michigan show that a modest investment of philanthropic funds can bring tremendous improvements in hospital and health service if the money is used to aid in the coordination of hospital service. This magazine congratulates the Fund on its forward looking decision.

One further experiment, however, is not enough. Hospital groups throughout the country, whether they have foundation support or not, should attempt to solve this problem. Methods are available and money can be found to use them if there is someone enthusiastically supporting the idea.

HEADLINE NEWS

Priorities Referral System Inaugurated by W.M.C.

WASHINGTON, D. C.—A further attempt by the War Manpower Commission to control the flow of male employes was made when the "priorities referral system" was made nation-wide on July 1. Under this system workers are to be channeled into jobs in accordance with the urgency of war needs. It is designed primarily to help foundries and forge shops, rubber and tire factories, ship repair, logging and lumbering and certain other war production activities.

This plan provides that employers in any area, except those in agriculture, may hire male workers only from among those referred by the U. S. Employment Service or in accordance with arrangements approved by the local U.S.E.S. Such arrangements may include hiring from other agencies, such as union hiring halls, colleges, universities and similar referral agencies.

An employment ceiling is fixed for each establishment in each of the 184 labor shortage areas in Groups I and II. These ceilings will not ordinarily prevent the employment of more women workers.

Part-time workers will ordinarily be excluded from the restrictions. Employers will have the greatest latitude that is possible in selecting workers and, similarly, workers will have as much latitude as possible in choosing jobs.

Every hospital should immediately get in touch with the local office or area director of W.M.C. so as to obtain as high a priority for the hospital as is necessary.

The plans will vary widely from one area to another, depending upon the demand and supply of workers. In some areas, hospitals may be given permission to hire their own workers directly.

Cadet Corps Celebrates Birthday

WASHINGTON, D. C.—Nearly 100,000 cadet nurses now in training celebrated the first birthday of the U. S. Cadet Nurse Corps on July 1, the date having been officially announced by Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, in whose office the corps was established. In 1064 approved schools of nursing throughout the country, groups of student nurses held simple birthday celebrations to fit in with busy student schedules.

A.M.A. Delegates Protest Policies of Army and Selective Service System

A strong protest against the policies of the Army and the Selective Service System in regard to medical students was adopted unanimously by the house of delegates of the American Medical Association and sent to President Roosevelt, the appropriate committees of Congress and the administrative officials concerned. The house met during the A.M.A. convention in Chicago on June 12 to 16.

The present policy "will inevitably result in an over-all shortage of qualified physicians with imminent danger to the health and well-being of our citizens," the resolution declared.

Rest in bed came in for severe censure by many of the physicians. Dr. William Dock of Los Angeles stated that complete bed rest must always be considered as "a highly unphysiologic and definitely hazardous form of therapy. In most cases the evil effects of complete bed rest are potentiated by anesthesia, narcotics, other medication or by the results of the original illness. But it must also be recognized that many disturbances of function, such as massive collapse of the lung, blamed on operation, illness, anesthesia or medication, have become evident only because the patient was forced to spend hours or days in the dorsal recumbent position."

Other doctors joined Doctor Dock in excoriating complete bed rest.

The Council on Medical Service and Public Relations stated that it could "not countenance the propaganda" from the Children's Bureau in favor of well-baby clinics for E.M.I.C. patients.

The council also recommended that the bureau of medical economics be a subdivision of the council. It suggested that the A.M.A. take a more active part in encouraging voluntary medical and hospital insurance by gathering facts, educating physicians, meeting with the directors of voluntary medical care plans and state associations, cooperating with Blue Cross plans, studying commercial insurance and consulting labor and employer organizations. It recommended the employment of a director of medical prepayment plans.

Dr. G. Lombard Kelly, who has been secretary of the council since January 1, resigned effective July 1.

The resolution of the California Medical Association requesting that Dr. Olin West be retired as A.M.A. secretary and general manager and that Dr. Morris Fishbein be replaced as editor was defeated after the house of delegates had refused to vote on it by written ballot. Doctor West was then reelected by the house. Dr. Roger I. Lee of Boston was chosen as president-elect.

Location Influences Physicians

The influence of hospitals on the location of physicians was clearly portrayed by Dr. Joseph W. Mountin of the U. S. Public Health Service. In six states with less than two general hospital beds per 1000, in 1940 there were 1141 people per doctor, while in 10 states with 4.5 or more beds there were only 522 people per doctor. "The presence of a hospital alone, with or without a high level of wealth, serves to attract and retain a physician," Doctor Mountin declared. This is even more striking when the analysis is confined to the younger doctors, he said. The maldistribution of physicians has grown even worse during the war.

Doctor Mountin urged the expansion of group practice so that maximum utilization could be made of the professional capacities of all physicians, thus increasing the service available by about 25 per cent. Group practice should preferably be connected with hospitals or health centers, he said.

The physicians were called upon by V/A Ross T. McIntire, surgeon general of the Navy, to provide "a sound plan for medical care that will take into consideration the millions of people in this country who are in the low salaried groups."

Point Purchasing Power Adjusted

WASHINGTON, D. C.—Because the 50 per cent reduction in red point purchasing power worked a hardship on some institutional users, an amendment to R.O. 5 on June 5 provided hospitals and other institutions with the means of making an upward adjustment in their May-June meat-fats allotment if their base period use was principally of beef steaks and roasts or dairy products which still require the surrender of red ration points. It is reasonable to expect that such an adjustment will be made, other conditions being equal, for the July-August allotment.

Technical and Professional Equipment for Hospitals and Related Institutions

By YELLENA SEEVERS
Analyst, Hospital Section, W.P.B.

Analysis of the W.P.B. orders and press releases concerning technical and professional equipment reveals little, if any, change. The latest information concerning the availability of such equipment is as follows:

Dental Equipment (Order L-249)—Production of dental units and chairs is restricted to base period quota. Manufacturers are charged with the responsibility of determining relative essentiality.

Dental instruments and supplies, except dental burrs and hand pieces, are or will shortly become readily available. All equipment involving fractional horse power motors is critical.

No preference ratings are being authorized on dental equipment and supplies. MRO ratings may be used only for dental lathes and such other dental apparatus or equipment as has general industrial utility, that is, for such instruments as bending pliers, files, small metal saws, that might be used in dental laboratories.

Laboratory Equipment (Orders L-144 and P-43)—Specific authorization from W.P.B. on Form WPB-1319 is required only for equipment that is included in List A of Order L-144. All other items of laboratory equipment may be procured by assigning the preference rating allowed under the Order P-43 to your purchase order. This rating should be adequate to obtain reasonable delivery on laboratory equipment.

Most of the equipment on the List A is scarce; therefore, hospitals, health departments and similar institutions are urged to continue to get along with the equipment on hand. When applying for such equipment, be sure to request only the less critical makes and models.

Binocular Microscopes. Prisms and other component parts are scarce owing to shortage of skilled craftsmen. Institutions in need of additional microscopes should apply for monocular or monocular convertible models, which can be fitted with binocular body when the military needs for equipment utilizing prisms and other critical component parts have been fully met.

Stereoscopic Microscopes. These are very scarce; however, hospitals can obtain low-power accessories (eye-pieces and objectives) for their medical microscopes or can purchase a wide-field tube for their purposes.

Centrifuges. Deliveries of certain makes and models to civilian institutions cannot be made for several months; institutions should apply only for the less critical makes and models.

Microtomes. Present production of microtomes is such that anyone having reasonable requirement may receive the necessary authorization.

Electrometric pH Meters. Most models of electrometric hydrogen ion meters are still critical and only the most urgent requirements can be filled.

Refractometers. For the next few months new equipment can be released only to those doing direct military work.

Spectrophotometers. Certain models remain critical while others can be released only for justifiable purposes.

Analytical Balances. Chainomatic models are scarce; institutions should apply only for the simpler types of analytical balances.

Medical and Surgical Equipment and Supplies—Manufacturers are being given sufficient materials to build enough equipment to fill the essential requirements. Preference rating is not required. Order L-214, Schedule 3, as amended June 9, 1944, permits use of metal in the production of certain hospital equipment.

Physical Therapy Equipment (Order L-259)—The amendment of Order L-259 permits manufacture of additional items of equipment, such as low voltage generators and short-wave diathermy units, for hospital and general medical use. However, immediate delivery of such equipment to civilian institutions is doubtful owing to the critical nature of certain of the component parts. (Specific authorization from W.P.B. is not required.)

Sterilizer Equipment (Order L-266)—Manufacturers of pressure sterilizers are working at full capacity and deliveries of sterilizers to civilian institutions will continue to be slow. When making applications for such equipment, requirements should be kept to the minimum.

X-Ray Equipment (Order L-206)—Even though specific authorization from W.P.B. is no longer required, only the most essential equipment should be ordered during the next few months. Many of the larger manufacturers of x-ray equipment are behind in deliveries to civilian hospitals owing to previous production limitations.

Adopt Rating Pattern for Cotton Textiles

By EVA ADAMS CROSS

WASHINGTON, D. C.—Though the textile order M-317 was amended May 29, W. S. Brines of the hospital section declared the amendment had no particular effect on hospitals. Hospitals are no worse off and no better off than they were before, he said.

The adoption of an urgency rating pattern for the cotton textile industry, regulating production of all cotton fabrics, yarns, cordages and twines in the order of their importance to the war program and the civilian economy was announced June 12 by W.P.B. Under this rating pattern all cotton textile mills are rated according to the essentiality of the item produced. The War Manpower Commission's manpower priority committee, using this pattern for guidance, may channel such new labor as is recruited to those mills that are producing items most necessary to meeting military and civilian needs.

High production urgency ratings have been indicated on the schedules of the following fabrics: Osnaburgs, soft-filled sheeting, class A, B and C sheetings, carded and combed poplins, diaper cloth, broadcloths, bandage cloth, chambrays and shirtings, Turkish and terry-woven towels, toweling and dish cloths, wash cloths, bath mats, blankets, blanketing.

Funds for Children's Bureau

WASHINGTON, D. C.—On May 12 the President approved a bill appropriating a sum of $6,700,000—a deficiency item—to the U. S. Children's Bureau for emergency maternity and infant care in the fiscal year that ended June 30. The additional sum is necessary because the number of wives and infants applying for care under the E.M.I.C. program has exceeded expectations. Before the Senate at the time of going to press was a bill for the appropriation of $42,800,000 for the fiscal year beginning July 1 for the financing of this program. The funds were carried in the 1945 Department of Labor appropriation bill.

Problem in Uniforms

WASHINGTON, D. C.—Efforts are being made by the American Hospital Association, the U. S. Public Health Service and others to obtain a better system for providing student nurses' uniforms. Several hospitals on the West Coast have reported serious difficulties in obtaining uniforms, according to Everett W. Jones, who has been compiling information on this subject for submission to the Office of Civilian Requirements of W.P.B.

PARTNERS

with other private and governmental agencies

BASIL C. MacLEAN
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I HAVE taken Doctor Gregg's statement as my text for this discussion because it forecasts changes that will affect our hospitals and because it suggests a broad and realistic approach to all planning. So much of the postwar planning one hears about in our hospitals has to do with bigger buildings and more beds that it is refreshing to see stressed the need for better medical and hospital care.

It is hazardous in some circles to mention that change is inevitable in all things. One risks the red label for none is more sensitive than the advocate of *status quo*. I dare not be dogmatic for there is so much that I do not understand. What is more, I suspect all of you are familiar with the statement of Goethe: "It is only when we know very little about a subject that we are quite sure; and with knowledge, doubt grows." Nevertheless, I should like to venture a few predictions.

It is apparent that the advocates of group practice of medicine will have a much greater following in the years after this war. The advantages of professional teamwork have been demonstrated to many thousands of medical men in the armed forces and many of these men believe that in civilian life these advantages may be offered by group partnership and without appreciable loss of individual independence.

Although the salaried practice of medicine is now found mainly among the faculty members of teaching hospitals and although the fabric of this system has been weakened by the demands and the opportunities of war time, it is suggested that after the war there will be an increase in the number of hospital appointments on a salaried full-time or part-time basis in many of our voluntary hospitals.

It is suggested further that the request for such a development will come from the clinical members of the professional staff of hospitals and not only from the members of laboratory and other ancillary departments. The hospital of tomorrow must be conducted in a business-like manner and be subject to the dictates of economics and of common sense but, I believe, there will be less bickering over who gets a fee, from whom and how.

An increase in the number of diagnostic clinics conducted by hospitals will be only a response to an obvious need. But the problem here encompasses more than community teamwork.

The proposed regionalization of hospitals in Great Britain sets a pattern that has attracted attention in this country and Proger of Boston has dealt with this subject in a recent article describing the work of the Bingham Associates Fund. As he explains it, the medical center "should serve as a source of specialized aid" and not be just "another building with more beds for patients with pneumonia or heart failure or for those who require appendectomies and herniotomies. In other words, it should not be simply another hospital. The mass of work should be done locally by community hospitals, more advanced work should be done in regional centers and only the final filtered cases

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"The danger for medicine in America lies in failure to acknowledge and to study the sociologic aspects of medicine—the social matrix. We are loath to see that research and teaching, as well as the practice of medicine, will change when change comes in the prevalent interpretations of the rôle of government and the structure of our society.

"The status of the physician is changing from that of being a private luxury to becoming a public necessity and the more so when taxation, poverty and the losses of war diminish private luxury to the vanishing point.

"I do not want the private practice of medicine to disappear nor do I believe it will. Our public school system is socialized education. It did not destroy the private schools. The concept of free, public primary and secondary education, later followed by free universities, was extraordinarily inclusive in its sweep. It, too, was a radical departure from the traditions of an earlier form of society.

"Public school education was challenged by those who believed that education was an individual relationship, had always been so and could not be made a mass affair. The cost of giving every child a grammar school and high school education was decried as unbearable and its practicability denied because of the inadequacy in numbers and training of teaching personnel.

"We have forgotten the long delays in the growth of public education, but after almost a century of effort, growth and improvement there has come a triumph for our grandfathers' conviction that a literate citizenry, even at a great cost, is the best guarantee of a democracy. What is now wanting (though war-time demands more than suggest it) is a similar belief that a healthy citizenry is an equally important guarantee of a strong and free nation."

(From an address, "The Matrix of Medicine," delivered at the Centenary Exercises and University Convocation of Western Reserve University School of Medicine, October 1943, by Dr. Alan Gregg, director for the medical sciences, Rockefeller Foundation.)

should be handled in the medical center."

I interpret this to include out-patient care also. A makeshift diabetic out-patient clinic with three visits a week is an anachronism when near by there is a well-organized one with every facility. To do these things, however, we shall have to overcome much of our individual hospital vanity and most of our interhospital jealousies.

The interrelationship of hospitals on a functional basis may extend logically to better programs for the training of interns, residents and student nurses. We must admit that in many communities a pooling of facilities for classwork instruction in some subjects of the nursing curriculum would provide better training for student nurses of participating hospitals. In a similar way, rotation schedules for interns and residents have been worked out among hospitals and a better training has been afforded.

Home Nursing Service to Fore

Under private or public auspices and for patients in almost all economic groups, home nursing service is a logical extension of the facilities of the hospital and it is probable that the use of it will increase. Some hospitals provide home nursing service for their obstetrical ward patients and out-patients. One need not be a visionary to predict that voluntary and governmental home nursing services will in the future be utilized more by all classes of patients before and after hospital care.

It is evident to all of us that the artificial barriers between preventive and curative medicine are being broken down. As the emphasis is shifted from disease to health the family in the civilized society of tomorrow will surely have easier access not only to a doctor but also to a health center.

The hospital administrator will be or, at least, should be less of a private bookkeeper and housekeeper and more of a public servant, educator and health officer. And here let me add a word of praise for those hospitals where efforts have been made to assist in the problems of screening of prospective inductees for service in the armed forces. By making available data of value in the examination of individuals these hospitals have made a real contribution.

Hospitals will be expected to provide facilities for finding unsuspected disease and more of the apparently well will come to us. The inclusion of a chest x-ray as part of a routine examination for all in-patients and out-patients is now a practice in some hospitals and will probably be as effective in disclosing unsuspected chest pathology as routine serology has been in detecting unsuspected syphilis.

We Must Work Together

Even at the risk of annoying some of my friends in the hospital field for whom I have the greatest respect and affection, I mention again the wisdom of and the need for a better working relationship between voluntary hospitals and governmental agencies at all levels. Without detracting in any way from the fine achievements under private initiative, and with a sincere hope that they may grow much greater, I suggest that we consider thoughtfully the degree to which hospital care is now furnished or financed by government.

The income received from the government by many voluntary hospitals has increased markedly during the last decade and a stability of finance on a service unit basis is bringing a measure of independence which hospitals could never obtain with a tin cup.

Read the G. I. Bill of Rights recently passed, and consider its implications. Consider the responsibility of the Veterans Administration for medical and hospital care of former servicemen and the monies that have been appropriated to provide additional facilities for the purpose. Consider, too, the forces now operating and the influences that may be brought to bear during and after this war on matters that vitally affect our voluntary hospitals. Then let us decide whether it is better to work with or against these agencies of our government—whether it is better to throw bricks or to lay them.

The avenues for participation by a hospital in public health activities are many and varied and new vistas open each year. Cancer control programs have encouraged the use of special clinics in hospitals for the periodic examination of women of cancer age. The venereal disease problem will be dealt with more realistically as it becomes a matter of medicine more than of morals. But these are only illustrative.

On the other hand, the hospital, with great advantage, can make use of the facilities of the local health department. For example, the technics and procedures of caring for the new-born should, I believe, be standardized by hospitals within an area and in consultation with the health department. In one community, such assistance from the health officer has solved a simple problem of recurring outbreaks of gastro-intestinal infections in hospital nurseries.

Within limitations imposed by character and size of the community the voluntary hospital of tomorrow should house either the headquarters or a branch of the bureau of health.

The American Hospital Association now regards public relations as an important activity of the association and of its member hospitals. Around National Hospital Day has been built a system of awards on the basis of newspaper and other publicity. Without disparagement of this, I suggest the greater propriety of emphasis upon the public health activities of a hospital even to the extent of an annual award.

The Choice Is Ours

The voluntary hospital as we know it today may choose to be strictly a private enterprise with little claim to public service, self-centered, concerned only with curative medicine and only with patients in certain economic strata. Or it may choose to be a part of an expanding program of community effort for public health and welfare, responsive to public needs and a partner with other private and governmental agencies in these fields.

The one path will lead, I believe, to a system of private nursing homes or hotels for sick people and another separate system of governmental hospitals with broad responsibilities. The other path, I am convinced, will bring the voluntary hospital to a position of preeminence among American institutions and to a measure of usefulness greater—much greater—than it has yet attained. I like to think that we shall choose the latter.

A Public Health Doctor's View

What you can do for community health and what public health agencies can do for you

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COOPERATION, according to the dictionary, means "collective action for mutual profit or common benefit." In actual practice two requisites are needed before full cooperation can be obtained. These are, first, a knowledge and understanding of the facilities and aims of each other's organization or institution and, second, a willingness to give as well as to receive.

Public health is difficult to define. There are numerous definitions—most of them long. A simple rule to keep in mind is that public health programs, in general, deal with matters of individual or community health that are of such nature or magnitude that public funds may be spent to protect the present population or the future of the population.

In other words, is the problem big enough for your tax money to support the same as it supports police and fire protection. You will note I say public funds "may be spent" because there are a large number of voluntary or gift-supported agencies that have been blazing the trail in public health fields before public officials have recognized the need for the services. An outstanding example of this are the many visiting nurses' associations.

Fit Program to Locality

Obviously, public health programs vary to fit the needs of the population they serve, the laws of the state and the funds available for health programs. A public health program conducted in a wealthy rural county in the Middle West is quite different from that conducted in a poor rural county in a southern state with a large Negro population, yet both counties need and are willing to support a health agency.

Regardless of the part of the country, regardless of the population served, there are certain fundamental responsibilities that public health agencies recognize. These are:

Five Duties to Community

1. Control of communicable diseases, including all diseases that may be transmitted from person to person or from bird, beast or insect to man.
2. Protection of the health and promotion of better health for the next and future generations (maternal and child health).
3. Maintenance and study of the vital statistics—birth and death records.
4. Promotion of general sanitation of the environment.
5. The most recently accepted responsibility is that of the protection of the health of the men and women doing the work of the country, *i.e.* industrial health.

We have three general methods of accomplishing our aims: (1) we promote legislation that requires things to be done by law; (2) we educate people so that they will do what we wish voluntarily; (3) we do it ourselves, that is, we give service directly.

Two of the three chief types of field personnel, the physicians and nurses, have had, as part of their training, experience in hospital routine. (The third type of field personnel is the public health engineer.) I mention this to call attention to the fact that a large number of public health workers have some understanding of hospital problems. Only a few hospital people, including superintendents of nursing schools, have had actual public health experience.

This brief general discussion of public health has been given partially to explain the aims of the public health program. Individually, you should make sure that you know the public health facilities of your community and state, the tax-supported and voluntary subscription-supported agencies. You may find them more useful than you now realize.

In order to achieve complete cooperation between the hospitals and public health agencies, some more specific suggestions can be made. There are ways in which hospitals and public health agencies can work in more accord in all of the five responsibilities mentioned; however, for brevity, I shall discuss in detail only the first two.

Control of Communicable Diseases

Control of communicable diseases has long been a function of official health departments and is now more than ever important because of the possibility of some war-time epidemic. In order for us in public health to control the spread of communicable diseases, we must first know where they exist.

Every state has a list of diseases that are supposed to be reported to the health department. We rely on the physicians to report them; however, reporting is far from perfect—and that is a universal fact. Too often the cases occurring or diagnosed in hospitals are never reported because no one takes the responsibility of reporting them to the proper agency.

It may be just one case of typhoid fever in your hospital, and the only one in the city, yet that case may be the link between cases in another area and the carrier who is the source of the disease, and reporting it promptly so that adequate investigation can be made may prevent further outbreaks.

One case of undulant fever, for example, reported promptly might

prevent an epidemic of the disease from some insanitary dairy.

Tuberculous cases are highly complex public health problems: how many individuals has a case exposed, and do these contacts appreciate the significance of the exposure? It might be just a case of tuberculous meningitis to you but to us it means that among the associates of that child is someone with an open case of tuberculosis who is a menace to others and very likely is unaware of the condition.

Reporting Venereal Disease Cases

The case of gonorrhea or syphilis may give us valuable information in locating a prostitute who has been the cause of other cases and is a potential source of many more. In regard to syphilis, you as individual taxpayers have a right to demand that these cases have sufficient treatment to prevent them from being public charges in a mental disease institution. We must know where and who they are so that we can give you that assurance.

In most hospitals, placing the responsibility for reporting is the main difficulty, interns are unreliable, staff men are too busy and nurses are not the diagnosticians.

I suggest some such routine as the following: The head nurse, or nurse in charge, reports to some central office (business office or nurse's office) the existence of a reportable disease and the central office has the intern or staff physician sign the report forms and forward them to the health department, if possible, within twenty-four hours after the diagnosis has been established.

Most health departments have printed forms with the type of information desired for the reporting of the various diseases. The hospital could maintain a supply of these.

Teaching hospitals should emphasize the importance of reporting to the medical students, possibly by giving them some responsibility for doing it, under supervision, of course. They might be more ready to report communicable diseases when they get out into practice if they have had to do it as part of their routine in training.

It may seem that these reports merely accumulate figures on the prevalence of disease. Let me assure you that an up-to-date health department uses these reports as a working basis for tracing sources and spreading appropriate information so that the spread of these diseases can be checked and their complications modified.

What can the public health agency do for you in this respect? A health department could send you regular bulletins of the prevalence of the communicable diseases in your area so that you might have some idea of what your pediatric admissions have recently been exposed to and place them in your wards accordingly.

In some states, the health department maintains a supply of various forms of convalescent serum that are helpful in the treatment, modification or prevention of some diseases, such as whooping cough, measles and scarlet fever. An epidemiologist might be able to help you in cases of epidemic diarrhea of the newborn or other forms of disease epidemics within your institution. Perhaps you have some ideas on this subject yourself. If so, why not talk them over with your public health agencies!

Maternal and Child Health

In promoting maternal and child health our chief method is that of education. We are opportunists in this respect; we try to give the information at the time when the "pupil" is most in need of it and usually most receptive. A young mother home from the hospital with her first baby is a good pupil. She has a lot of things to learn in order to adjust herself and the household to a new baby, and she usually gets a great deal of conflicting misinformation from the grandmas and the neighbors.

A public health nurse's visit at this time would be so useful and usually so welcome that further suggestions by the nurse in regard to the health of her baby as he grows older would be more likely to be accepted and carried out. Some of the misinformation might be discarded for correct information. I could relate many actual incidents in my own experience of the value of this type of call. It provides an entrance into a home and an acceptance of health teaching that cannot be obtained under other circumstances.

You would be giving support to the public health nurses who are interested in maternal and child health by referring the dismissed obstetrical cases to them, not at the end of the week or month but the day they leave the hospital or, better still, the day before they leave.

Do this routinely for your low-income patients and give the other pations information as to how they can get in touch with a public health nurse if they want one. This could be done by the head nurse or supervisor of the obstetrical department either directly or through a central office in the hospital.

In the case of state university hospitals to which the patients come from distant places it might be a better policy to notify the public health nurse on the day of delivery and give the possible date of the patient's dismissal so that she can have the information in time to be of service. This could be done by sending the information to the state bureau of public health nursing and letting this office relay it to the appropriate local nurses.

Remember, health information is a universal need—it is not just the poor or the uneducated who need it. Experience in the field has shown that most people welcome health information if it is practicable and is available when needed.

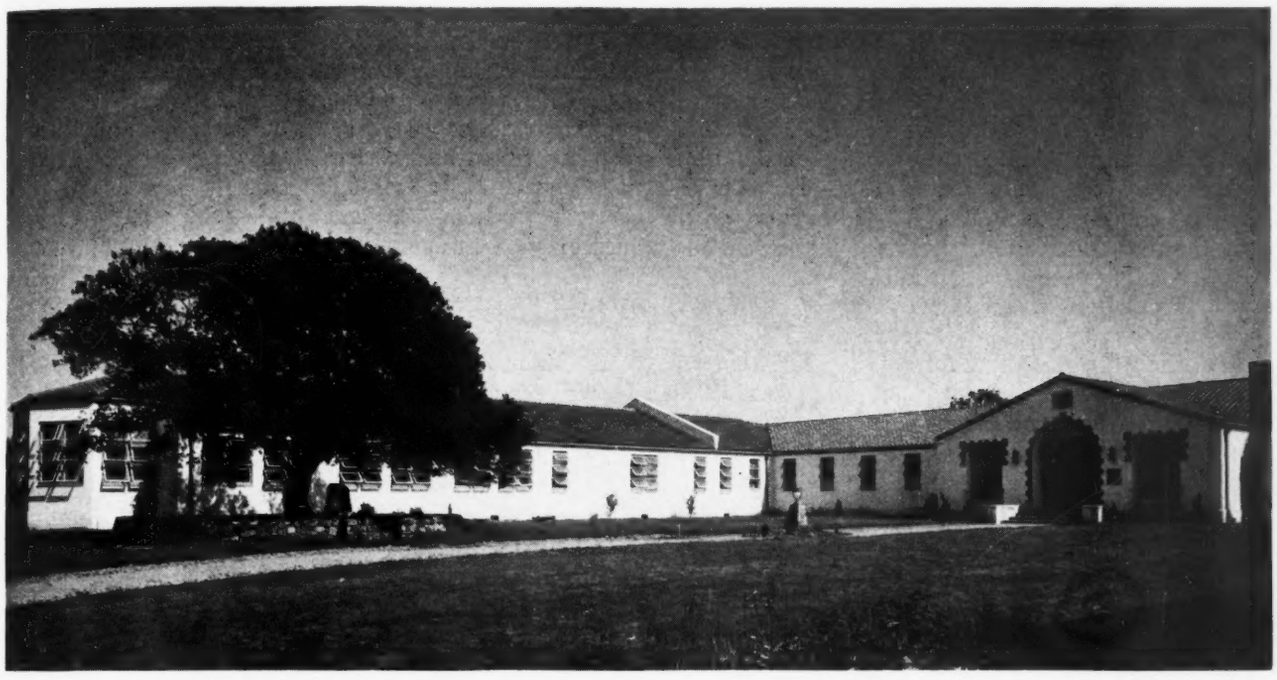
Examples of Aid to Hospitals

What can we do for you? There are several things that I shall list without discussion.

1. We could make prenatal visits to your prenatal patients registered for ward care if you have this type of service. Prenatal classes for your clinic patients, and for private patients too, could be given, if desired.

2. If the hospital is cramped for space, obstetrical cases could be sent home before the usual eight or ten days and a public health nurse could visit that patient in the home to give care or demonstrate care for some reliable member of the family to carry out for the rest of the lying-in period.

3. If a clinic patient fails to return for the customary six weeks' checkup, a public health nurse might be able to convince the patient of the importance of this check-up and succeed in making her return.



Rural County Attacks Tuberculosis

E. DWIGHT BARNETT, M.D.
Director of Health
Sonoma County
Santa Rosa, Calif.

THE experience we have had in Sonoma County, California, in coordinating public health educational activities, the voluntary work of the local tuberculosis association and the excellent treatment facilities of a modern sanatorium with specially trained personnel has shown remarkable results in eliminating tuberculosis as a hazard in the community in a very short time.

Prior to 1938, Sonoma County had no adequate place for the care of the tuberculous; no sanatorium was available in the county, and the small private hospitals, most of which were homes made over into hospitals, would not take care of tuberculous patients. A few of the more serious cases were cared for by contract in a private sanatorium in another county, but only those who were extremely ill were hospitalized. Owing to the lack of hospital facilities early cases, where the biggest opportunity for cure occurs, were not considered.

At the same time there was no adequate health department in the county. An elderly, part-time physician, without public health training, quarantined reported communicable diseases and no other public health work was fostered. The National Tuberculosis Association was in existence at that time and about 1930 had put on a campaign to erect a tuberculosis sanatorium for the people of Sonoma County, but this had failed of realization.

In mid-summer of 1937 a new county hospital was finished in Sonoma County and was opened for the care of acute diseases among the medically indigent and later a portion of the old county hospital containing 36 beds was rebuilt and refurnished as a tuberculosis sanatorium. Only a few cases of tuberculosis had been reported each year prior to this time, and it was considered that these 36 beds would give ample room for the care of tuberculous patients of our county.

On July 1, 1938, the county inaugurated a full-time public health service with the employment of a trained health officer, public health nurses and sanitary inspectors. In setting up this new department the board of supervisors of the county felt that all of the health work of the county should be in one department so that optimum cooperation could exist between the preventive, or public health, side and the treatment, or hospital, side.

A Sonoma County department of health was created under the direction of a director of health who was to be a doctor of medicine trained in medical administration, the department to have four subdivisions.

The first was the division of public health, to be headed by a doctor of medicine trained in public health work and whose duties are the usual ones of enforcing the public health laws, giving public health services and educating the people.

The second, the division of hospitalization, includes the management of the Sonoma County Hospital, a 452 bed general hospital. The third division was that of out-patient clinics, which includes both public health and hospital clinics. The public health clinics were: venereal disease, chest or tuberculosis, prenatal and well-child conferences. Admission to any of these was not dependent upon ability to pay, as these were clinics operated under the California public health laws.

The fourth, the tuberculosis division, was a subdivision under the hospital and was headed by a trained tuberculosis physician and chest surgeon. He not only was interested in the curative aspect of combating tuberculosis but also was in charge of the public health aspects of the control of the disease.

Facilities Now Complete

With the establishment of a sanatorium in the old hospital buildings, there was a sudden influx of patients, and by April 1938 the institution was filled and more patients still were clamoring for admission. With the institution of the department of health, plans were made for the erection of a new tuberculosis sanatorium for this county. This building, with a capacity of 98 patients, was opened in August 1939, and from that time to the present the facilities for the complete supervision of tuberculosis were available for the people of this county.

Under the direction of Dr. Robert S. Quinn, chief of our tuberculosis division, a public health nursing section was set up and public health charts and a control map showing all families in which tuberculosis was known to be existent were instituted. The Sonoma County Tuberculosis Association, which had been a small organization with an annual seal sale of approximately $2000, immediately got behind the public health program of case finding, put in a full-time secretary and was instrumental in setting up an excellent case-finding program. This work has been so successful that the Sonoma County tuberculosis seal sale has jumped to $15,500 during the last year. The association works hand in hand with the health department and the sanatorium, and industrial and agricultural group case-finding surveys are held weekly in various parts of the county. The tuberculosis association will go to an organization, such as the poultry producers', in which there are many employes and cooperative members. It sells the idea of the survey to the employes and to the organization as a whole.

Case Finding in Community

The tuberculosis association owns a portable fluoroscope, purchased with Christmas seal funds, and this is taken to the plant at the time of the survey. The survey is conducted by Doctor Quinn, or his assistant, and the public health nurses of the health department, as well as the secretary of the Sonoma County Tuberculosis Association. Many new cases have been discovered in this manner long before they developed symptoms of the disease.

In the past we also have operated school tuberculin testing programs as case-finding units, but as these found only a few cases they have been almost completely abandoned in favor of the group case-finding program. We now use this school program primarily as an opportunity for tuberculosis education rather than for case finding.

We have also recently attempted to find cases by the fluoroscopic method in small communities on a community-wide basis. The tuberculosis association puts out preliminary educational material within the community and sets the time for the survey; excellent attendance has been the result of this type of work on a community basis.

The new hospital, named Oak Knoll Sanatorium, was filled almost immediately with chronic tuberculosis cases and with children who had developed the childhood type of tuberculosis because they had been forced to live in families in which some member had tuberculosis and no place was available for the care of that person.

We have had a great number of cases in which the infection had developed in more than one member of the family because of the lack of both public health supervision and education and hospitalization.

It has been interesting to watch the difference in the type of cases that have come to us since 1938. By Jan. 1, 1939, we had 34 children of grammar school age in the sanatorium with childhood tuberculosis. We had a full-time grammar school teacher. This number stayed static for approximately a year and then began to drop off.

By September 1940, 22 young adults of high school and junior college age had been admitted to the Oak Knoll Sanatorium and a high school teacher was employed. The results of good hospital care with these younger people have been excellent, and we now find that all of these children are gone and our present school load is four grammar school and six high school pupils, with only one teacher to teach both groups.

Our present load of adults is made up of old cases and early cases found by survey in about equal proportions. By Jan. 1, 1940, the patient load at Oak Knoll Sanatorium had risen to 112 patients, and at the present time the Sonoma County load is about 70 patients.

The value of this work to the general health of the people of this county can probably best be shown by the statistics of the cases reported and the death rates for the years of this study. These are as follows:

Year	*Cases Reported*	*No. Deaths*	*Deaths per 100,000*
1937	62	59	91
1938	119	42	63
1939	96	27	40
1940	74	26	38
1941	72	19	28
1942	64	27	38
1943	56	23	33

This chart illustrates as well as anything can the results of a well-planned and coordinated tuberculosis campaign in a county. In 1937 when there were no adequate public health services available, when there was no adequate sanatorium program and when the tuberculosis association was inactive, only 62 cases were reported by the physicians of the county. Almost all of these 62 were reported in the death certificates only. They had never been recognized in a public health report previously. The death rate was 91 per hundred thousand, approximately twice the national average at that time.

In 1938 the new sanatorium facilities were first established, a director of tuberculosis was employed and a

health department was organized. The result was that there was a tremendous increase in the number of cases reported. This does not mean that we suddenly had an increase in the incidence of tuberculosis; it simply means that we suddenly had an increase in the recognition of tuberculosis and its existence in the county.

As the years went on our program of case finding increased, but even so the number of cases found was reduced. During 1942 and 1943 the fluoroscopic method of case finding was instituted and even with this the case rate has decreased.

The death rate per hundred thousand population shows a remarkable decrease, so that in 1941 it had dropped to 28 per hundred thousand. In 1942 a slight increase was noted in the death rate. This was due in part to an increased population of the southern part of the county and war housing in connection with Mare Island Navy Yard and the Basalt Ship Building Company of Napa. In the latter institution an extensive tuberculosis case-finding survey was conducted by the Napa County Tuberculosis Association and 41 suspicious cases who lived in Sonoma County were referred for our supervision.

It is also to be noted that the Sonoma County Tuberculosis Association's program of fluoroscopic case finding started in 1942 and was continued through 1943, which would also have a tendency to increase somewhat the number of early cases found.

Hospital Men Need Educating

If the public health facilities are not coordinated adequately with those of the hospital, however, it takes a great deal longer to obtain results. I feel that hospitals and public health authorities do not know each other's problems sufficiently well to offer a good preventive medicine program. Public health officers should know more about the administrative problems of hospitals and administrative officers of hospitals more about public health.

There is a definite trend now in the United States Public Health Service to inculcate better public health information into the hospital administrative field. Suggestions have been made recently by members of the U.S.P.H.S. that a course or seminar in public health be given to interested hospital administrators. If this could be done the effect on good preventive medicine would be immediately noted and results such as we have obtained in our work with tuberculosis would be found in other fields of preventive medicine.

HEALTH EXAMINATIONS

can benefit hospitals as well as public

CLARENCE COOK LITTLE
Managing Director, American Society for the Control of Cancer

PERIODIC physical examinations of perfectly healthy individuals are excellent life insurance not only for the patient but for the hospitals. By spending a relatively small amount of time with a relatively large number of people who are physically well and normal the wall of fear between health and disease is broken down.

The public comes to consider the hospital as an essential part of normal daily life and will thus accept its authority and give attention to its advice in time of crisis as well.

Some Real Advantages

Several other benefits will also be derived by the development of resources at hospitals for large numbers of physical examinations of persons without symptoms:

1. A bridge of understanding and sympathy between the hospital and the general practitioner. The great majority of conditions discovered at such examinations can and will be referred back to him and he will thus learn by experience that clinics and hospitals desire to supplement and not to replace his services.

2. The benefits of using expensive equipment in diagnosis will be given to the average patient. Not all general practitioners can or should attempt to use x-rays in diagnosis. Clinics can do so and can thus do much to maintain high standards.

3. A vast body of data on the physical condition of normal persons will begin to accumulate. Strangely enough, this is a responsibility that no one as yet has cared to assume. No lasting understanding of human biology will be reached until the collection and analysis of data of this sort are established as routine procedures.

4. Our knowledge of the incidence and extent throughout the population of the so-called degenerative diseases will be vastly increased as will the chance of cure of such diseases wherever that is possible.

This fact has already been proved for cancer by the results obtained in the four so-called "prevention" clinics now in operation. The principle of early detection and diagnosis as a key to control is not sufficiently preached or practiced as a part of the fundamental service of hospitals.

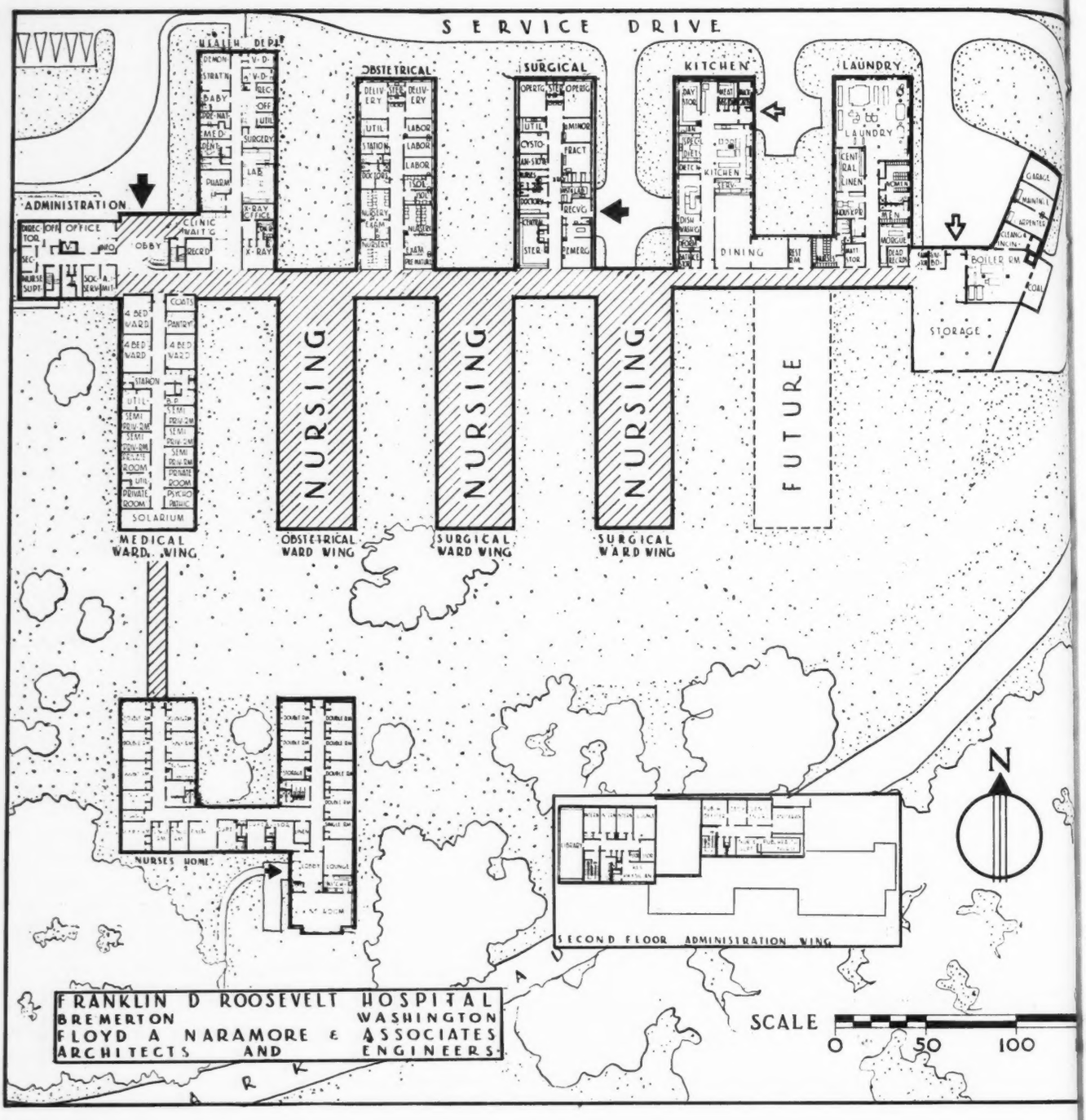
5. There will be greater opportunity to detect neurotics, hypochondriacs and psychopaths and to prevent them from seriously interfering with more critical periods of medical practice and care.

6. There will be greater interest in establishing increased efficiency in maintaining public health education at all levels of the educational system. This will provide a long-needed reenforcement of the attenuated and altogether too weak link between medical practice and public health officials.

Traveling Clinics for Small Towns

General practitioners in rotation or in groups might well agree to combine periods of service at such clinics with short refresher courses at hospitals, thus benefiting the individual doctor, the hospital and general public. Traveling clinics might be sent by hospitals to small communities to work with the general practitioner in such places on examinations on stated days per month or at other suitable intervals.

Abstracted from an address to the United Hospital Fund, New York, March 1944.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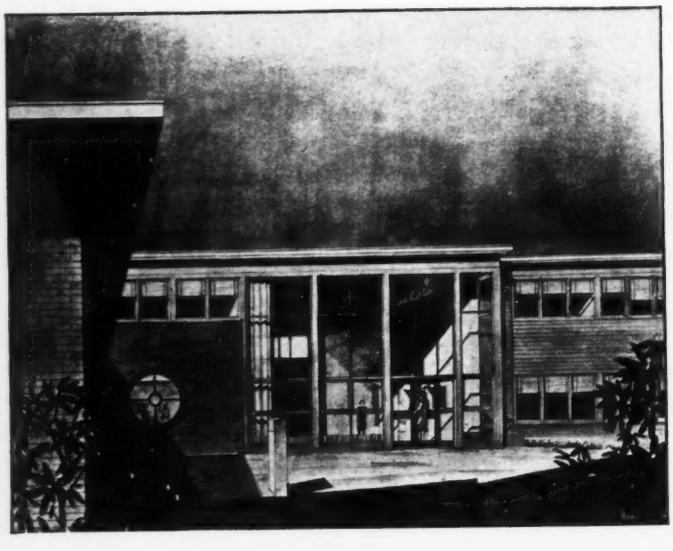
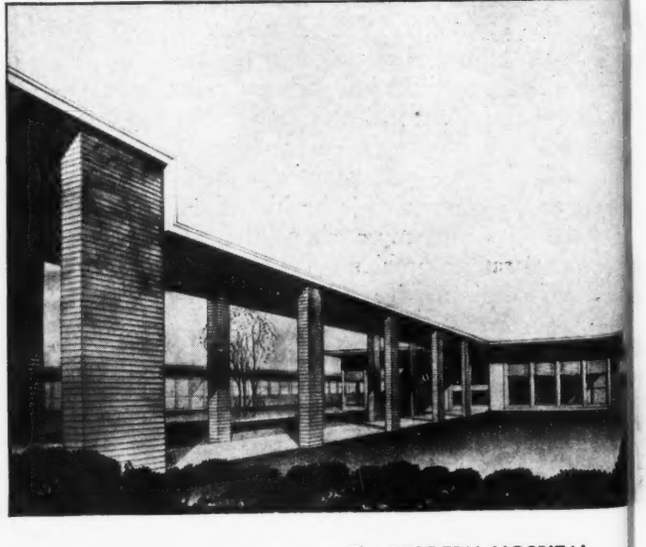
FLOYD A NARAMORE & ASSOCIATES
ARCHITECTS AND ENGINEERS





HEALTH CENTER

The Franklin D. Roosevelt Hospital, Bremerton, Wash., proves the value of coordination and cooperation • • •

RUSSELL H. WILSON, M.D.
Passed Assistant Surgeon (R)
U. S. Public Health Service

CAN the facilities of a hospital be coordinated with the activities of a local health department? The Franklin Delano Roosevelt Hospital and Public Health Center recently opened at Bremerton, Wash., is an answer to this question.

Bremerton is the principal city of one of the busiest war-industrial areas in the United States. It is the largest city in Kitsap County and increased 98.8 per cent in population from 1940 to 1943. The hospital service area of which Bremerton is the center includes Kitsap County, with a total civilian population of 136,196.

On March 1, 1943, however, only 153 beds were available in civilian general hospitals registered by the American Medical Association to serve this entire area, or approximately 1.4 beds per thousand population. It was evident that something had to done to relieve the critical shortage of hospital and health facilities in an area overcrowded with thousands of Navy Yard, shipyard, airplane factory and other war workers and their families.

To solve this problem, a construction and operations program was inaugurated by the Kitsap County board of commissioners and the county-city health department. The result of this cooperative planning was the opening in January 1944 of the Franklin Delano Roosevelt Hospital and Public Health Center in Bremerton.

The hospital is a 140 bed institution operated as a municipal hospital by the county of Kitsap. Its unique feature is that it provides under one roof a modern hospital and complete facilities for the administrative and clinical activities of the health department. Such an institution, designed and equipped to house the various health programs, is a fundamental requirement in the application of the modern public health principle which looks toward the coordination of therapeutic and preventive services.

The building was designed by Johanson, Bain, Brady and Grainger of Seattle, in cooperation with the Hospital Facilities Section of the U. S. Public Health Service. Federal funds were made available under the Lanham Act.

The hospital-health center was planned jointly by the local health officer and his staff and a committee appointed by the local medical society to act as the executive committee of the medical staff of the hospital. Thus, the procedures determined by joint planning are satisfactory both to the health department and to the medical practitioner and the program does not interfere with, but assists, the private practice of medicine. The one other hospital in the community has been invited to participate in the coordinated program and to refer selected patients to the public health bedside nursing service.

Office space for the divisions of public health nursing, nutrition and sanitation is included in the administrative section of the hospital. Although such an arrangement may not materially enhance the program of the sanitation division, certain tests connected with sanitation can be carried out conveniently in the hospital laboratory. This laboratory and the x-ray facilities will be utilized by both the hospital and the health department.

The community agencies, which in the past have supported the activities of the health department, will continue to contribute money for health work. In this way, the new program will not impose an undue burden on the financial resources of the hospital.

In planning the program of joint activities, it was kept in mind that although it is not the responsibility of the hospital to assume an educational program, it is its responsibility to cooperate with an organization that is prepared to carry out this function. Since education is one of the primary functions of public health, the staff of a full-time local health department is prepared to assume this responsibility.

The program of the Franklin Delano Roosevelt Hospital and Public Health Center is founded on three concepts: That early, adequate and educational hospitalization is a principle of sound public health; that differentiation cannot be made be-

Opposite page: Plot plan and two views of the new combined hospital and health center. The activities of the health department are carried on in the administrative wing shown at the upper left. Here are housed the offices of the divisions of public health nursing, nutrition and sanitation. The laboratory will be utilized by both the hospital and the health department.

tween health benefits of early hospitalization and a public health program because such hospitalization is both an intelligent public health procedure and a preventive medical measure, and that means must be made available by which a large percentage of the population may receive this health care.

To carry out this program, selected hospital patients should have health instruction during hospitalization by people trained in public health work, and an efficient follow-up system should be established. There are no two groups of professional people in the medical world more willing and better qualified to develop a program of public health and hospitalization than the staffs of a well-organized health department and hospital.

At the new hospital and health center many types of patients will receive instruction from nutritionists and public health nurses. The public health personnel also will be required to assist hospital personnel in developing the public health teaching attitude while working with specific types of hospital and clinic patients, such as maternity and child welfare cases and patients with tuberculosis, venereal disease and other communicable diseases. Hospitalization will then be a period of recovery and of instruction that will teach the patient how to prevent the spread of communicable diseases and the recurrence of preventable conditions.

How can a large percentage of the population be given this early, adequate and educational hospitalization? In Bremerton and Kitsap County, the Blue Cross hospital service plan supplies both method and means. Families and individuals on the lowest economic levels can afford membership in this hospital insurance scheme. The health department does not assume financial responsibility for hospitalization. This is the individual's responsibility. Costs of hospitalization are either postpaid or prepaid by the Blue Cross plan, by the individual or, in some cases, by the welfare department.

It is the purpose of this program to prevent as much illness and discomfort caused by disease, social problems and insanitary conditions as possible. The health department does not assume responsibility for the various phases of social work which are the functions of the welfare agencies. But it has a definite responsibility for public health education in all phases of medical and social work. Its responsibility is not limited to one social or economic group.

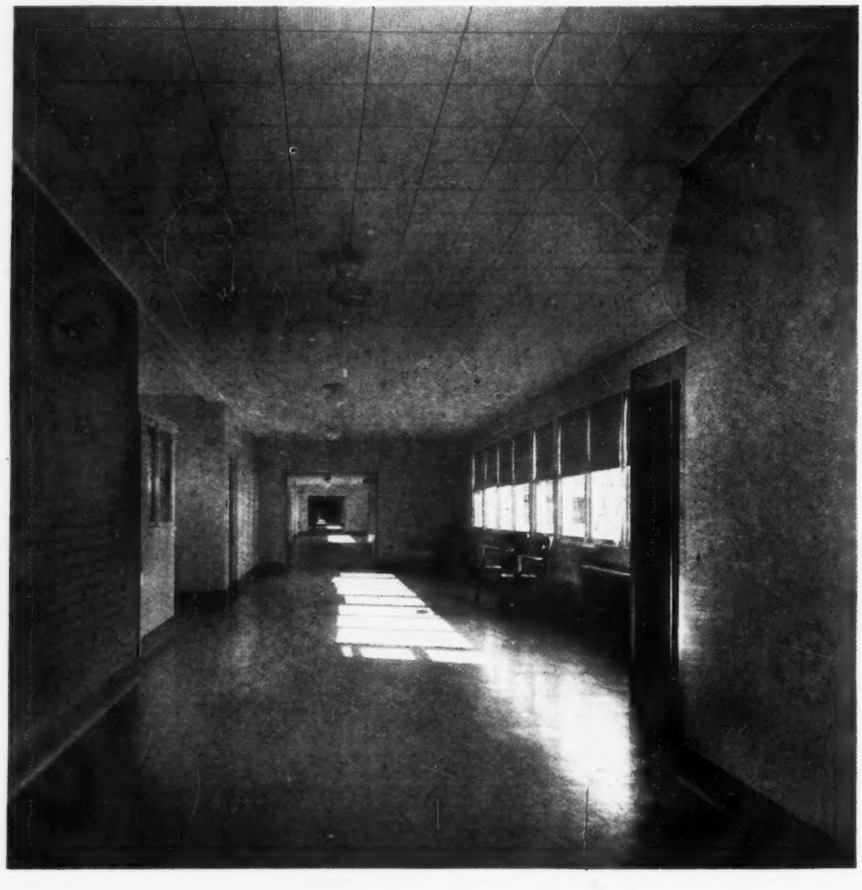
The department of public health furnishes services and health information that are vital to all of the members of a community. Even the most highly educated people can well utilize the teaching and suggestions offered by the staff of the public health department.

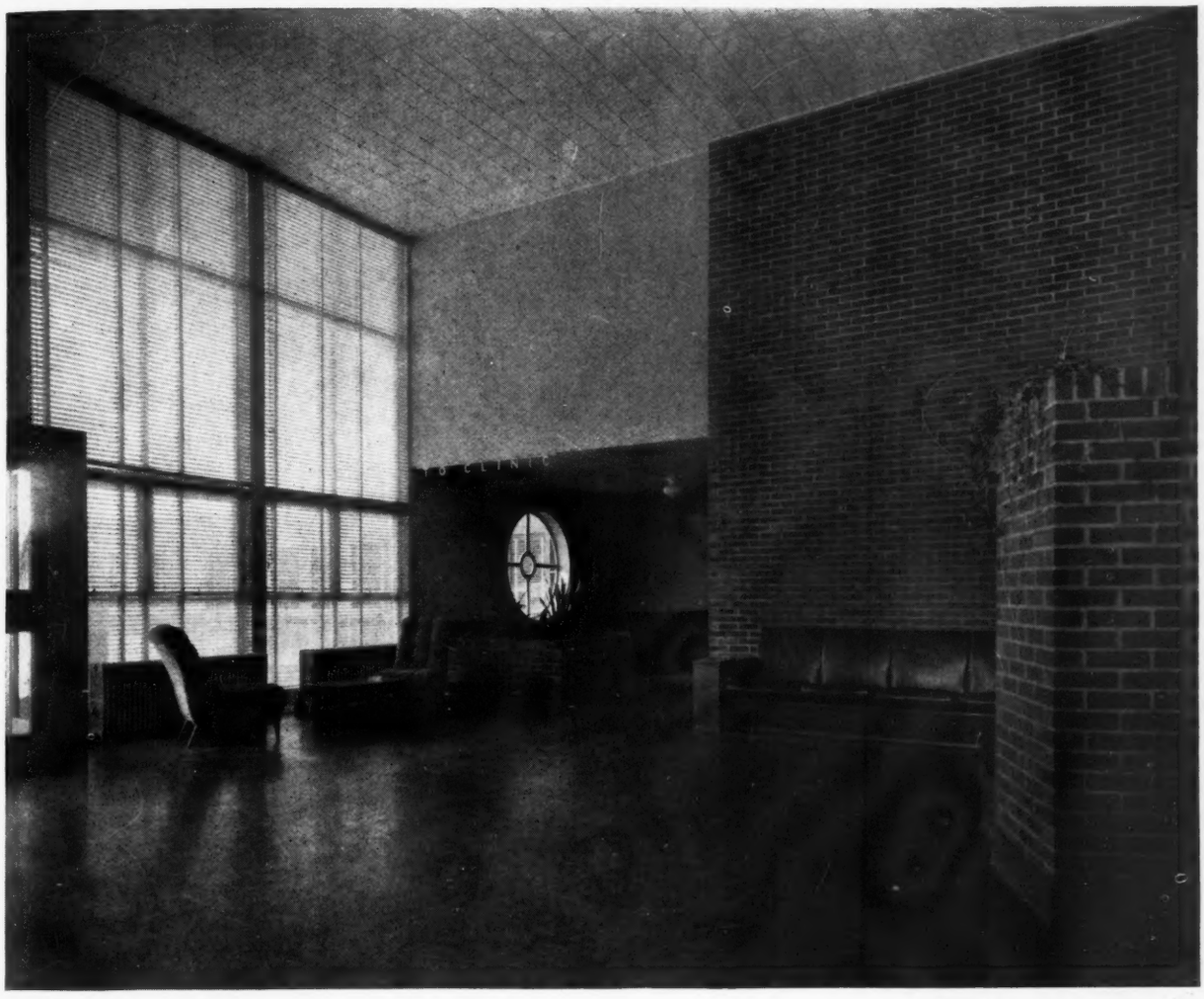
In the Bremerton and Kitsap County area, visiting or bedside nursing has been included in the public health nursing program in cooperation with the American Red Cross. This advancement in the field of public health nursing makes the official health department even more valuable to the hospital unit. During her home visits, the public health nurse often comes in contact with patients who need hospitalization. It is her responsibility to encourage these patients to consult their doctors; through her efforts and on the advice of the physician, the patient will ask for early hospitalization.

It is then the public health nurse's responsibility to help the patient and the family make the mental and social adjustments necessary for sound hospitalization. This includes, for example, the elimination of superstitious fears, domestic arrangements for care of the family if the mother is the patient and even referral to appropriate welfare agencies if financial aid is needed. This procedure is a preventive health measure, since freedom from worry and fear contributes to the patient's recovery.

After the patient has received instruction relating to his specific disease or condition while in the hospital and has returned home, certain nursing duties must be continued. A patient may need one or two hours of daily nursing care, but it is not necessary for him to remain in the hospital if such care can be given adequately at home. The logical person to carry out this home nursing is the public health nurse whose duties have been extended to include bedside care.

The maternity program of the Roosevelt Hospital and Health Cen-





Opposite page: Corridor connecting units of the hospital.

Above: This waiting room serves both the clinic and the hospital.

ter is an example of our planned approach. The public health nurses have an established place in the maternity program throughout the area. They follow the maternity patients, instruct them individually, conduct prenatal hygiene classes and help to make arrangements for the confinement period. They will conduct a maternal hygiene class once or twice a week to give prospective mothers public health instructions so that they may go through the periods of gestation, delivery and postpartum care with as great a degree of happiness and good health as possible.

The public health nurses will give similar services to mothers who are delivered in the hospital and who have not had prenatal instruction. Before these patients return to their homes they will have been taught how to prepare the baby's feeding formula, prescribed by the private physician; how to give the baby a bath, and how to take care of themselves after leaving the hospital. The out-patient department also includes facilities for a weekly well-baby conference.

There will be a tuberculosis clinic that will be open to both private and nonpaying patients in the community. The personnel of the health department will follow up the tuberculous cases, discover contacts and make arrangements for chest examinations of contacts. It is not planned, however, to hospitalize tuberculous patients in the general hospital.

A venereal disease clinic for the treatment of eligible patients who wish to avail themselves of this service will be part of the out-patient department program. Here again, the public health nurse trained to do venereal disease field work will follow up the patients in the clinic in home visits. Many venereal disease patients need hospitalization from time to time and can afford to pay for it. The hospital therefore plans to hospitalize selected patients for treatment.

Because of the remarkable development of modern methods of rapid treatment of venereal disease, it is imperative that the hospital designate a few beds for these patients. Eventually, the hospital will have personnel specially trained in intensive treatment technics. With specialists available in the hospital, it is believed that private practitioners will be able to use the rapid treatment methods on a much larger scale than is possible at present.

Although the hospital-health center has been open for only a short time, there is every reason to believe that, through its coordinated activities, it will be able to make a valuable contribution to the well-being of the civilian population in its service area.

Pooling Interns and Residents

HAROLD C. LUETH, Lt.Col., M.C.
Liaison Officer, Surgeon General, U. S. Army and American Medical Association
Consultant, Procurement and Assignment Service

THE so-called 9-9-9 program, introduced as a war-time emergency measure, has necessitated some profound changes in hospital schedules. There has been a reduction of nearly 60 per cent of interns and residents since 1940. Furthermore, periods of hospital service have been reduced to nine months each.

A certain amount of shifting of personnel and rearrangement of services was, of course, necessary during the transition to the new schedules. In general, however, a majority of hospitals have met the new situation well and there are indications that it has not materially reduced their standards of hospital care.

All hospitals realize that the reduction in the length of hospital training necessarily is reflected in a curtailed educational program. Some hospitals have changed from part rotating and part straight services to complete straight service.

It was felt that nine months' internship divided among several special services was little more than another clerkship, while nine months' training in one or even two general services provided thorough training in the latter fields which an intelligent physician could apply more broadly.

Shifts in Types of Intern Service

Many hospitals have changed a straight service in medicine or surgery to a rotating service, including pediatrics, neurology, psychiatry, obstetrics, gynecology, ear, nose and throat, orthopedic surgery and urology. The inclusion of additional services serves the dual purpose of providing adequate care of patients in the hospital and broadening the training of the intern during his short hospital training.

Too, it has been found that interns and residents with good rotating services are more valuable medical officers to the armed services than are those trained in a single specialty. The ideal training for a battalion surgeon is a course of hospital work in general medical and surgical service.

Hospitals have solved the problem of reduction in the number of house officers necessitated by the 9-9-9 program in a number of different ways.

Resident Becomes More Important

To stay within their quota, many hospitals simply reduced the number of interns on each service. This method was applicable only to large hospitals. Other hospitals reduced the period of training in medicine, surgery and the specialties. Still others simply enlarged their services of medicine and surgery to include the specialties. When the latter two plans were employed thoroughly competent residents were needed for good service to patients.

It seems to be the experience of most hospitals that intern services can be reduced and changes in personnel made at frequent intervals without too serious interference with patients *only if there is an adequate coverage by competent residents.*

A large charity hospital in the Middle West cut the length of its internship in half under the 9-9-9 program. This forced a reduction in the periods of intern training in specialties, such as pediatrics, psychiatry, tuberculosis and communicable diseases. It was necessary then to appoint residents in each specialty to ensure continuity of service and to exercise the necessary supervision over the frequently changing intern group.

Another large hospital pooled its quota with a smaller institution. A plan was devised allowing interns to serve a part of their internship in the larger institution and a part in the smaller hospital.

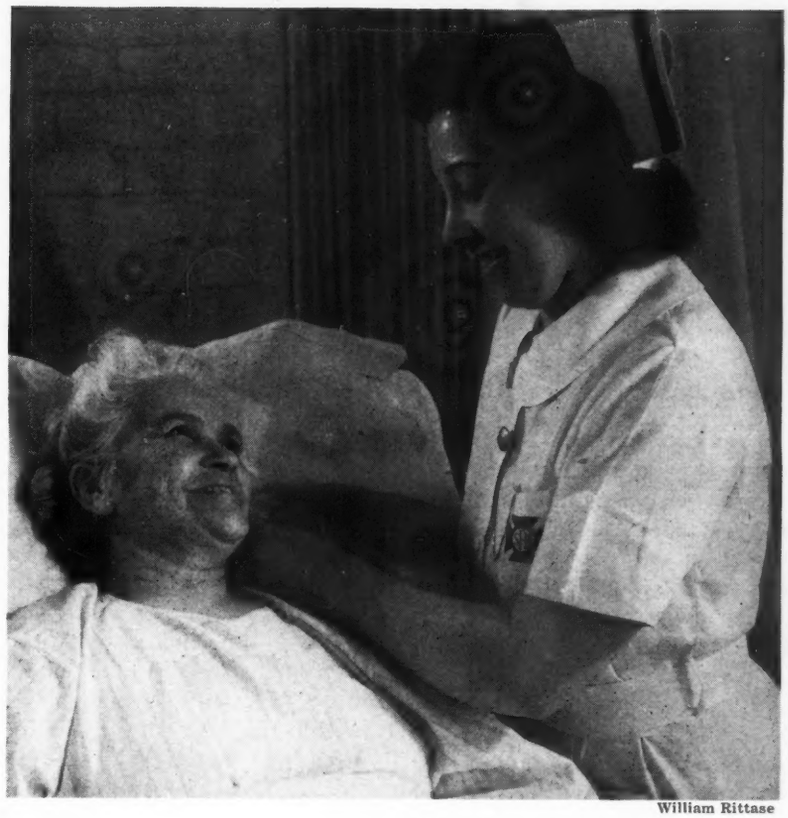
In some communities small hospitals have found it difficult to get interns under the 9-9-9 program because students are frequently attracted to larger institutions. By "pooling" interns the larger hospital in such communities was permitted to appoint more interns and share them with the smaller institution. Plans of this type are ideal on paper but they require close cooperation and mutual trust of all concerned to be put into effective operation.

Men trained under such a plan have the advantages of service in both large and small institutions, which in itself tends toward a broader point of view. Unfortunately, too few institutions have utilized this highly desirable cooperative venture.

Rotation of interns has been speeded up by the operation of the 9-9-9 program. For the most part hospitals have not felt that this has materially affected medical care of patients. It has been found more advantageous to appoint a man as a surgical intern and have him serve brief periods in orthopedic surgery, obstetrics, gynecology and ear, nose and throat than to appoint a single intern for each service. Much of the success of this plan depends upon the character and experience of the resident.

Obstetrical Service Suffers

It is frequently reported that obstetrical care has suffered most during the transition period. Several reasons for this are advanced: There has been a large increase in obstetrical admissions, and it has been said that the meticulous and numerous technics of good obstetrical care cannot be mastered by the average intern in the shortened period of training. Again, the best solution to these special problems seems to be in the careful selection of competent residents in obstetrics.



William Rittase

Efficient Nursing of Chronic Illness

A. C. JENSEN
Superintendent, Fairmont Hospital of Alameda County
San Leandro, Calif.

PATIENTS suffering from chronic illnesses range from those who are ambulatory and able to care for themselves to those who are bedfast and helpless. They include those who need little or no medical and nursing care and those who require the best and most intensive professional care that can be given only in a modern hospital.

Of those who can be cared for in their homes, some require only a limited amount of nursing care, which may be supplied by visiting nurses in communities where such organizations exist. However, as is frequently the case, the need is for both nursing and housekeeping, and these services can best be supplied by the trained attendant.

In planning for the care of the chronic disease patient, especially the dependent patient, there is fairly general agreement that he should not be forced, for economic reasons alone, to be separated from his family and segregated in an institution. If his illness is such that he can be cared for at home, with financial assistance, it is more desirable for the patient and more economical for the community to make such provision.

Those who need active medical and nursing care, however, must, as a rule, be given it in a hospital. Only there can the doctor and the nurse give this type of patient the help he needs. Providing satisfactory nursing service for chronic disease patients in our hospitals is, therefore, our principal problem.

Special Requirements in Nursing

This problem is divided into two parts, the first of which is nursing care that requires a high degree of technical skill. Acute complications frequently develop which, superimposed upon existing illness, require special skill in nursing.

Nurses who care for chronic disease patients should be intelligent observers, able to differentiate between actual and fancied ills. They must be trained in the psychology of the sick and must appreciate the value of and cooperate with the medical social worker, the occupational therapist, the librarian and the chaplain in helping maintain the patient's morale. They must possess real tact and firmness and, above all, an unlimited capacity for friendliness and kindness.

These requirements, plus the ability to train, direct and supervise assistants and students, indicate the need for the best nurses it is possible to employ in order to build around them an efficient, sympathetic nursing service.

The second part of the problem concerns routine nonprofessional attendant service.

For several years there has been an increasing recognition of the value of an auxiliary or attendant group to perform routine nonprofessional services for patients both in the hospital and in the community. The main reason for the extensive use of this group is probably economic. Increased requirements for admission, an oversupply of nurses, unemployment and low salaries during depression years greatly reduced the number of students entering training schools. This resulted in the closing of many schools, especially in small hospitals.

Scarcity Antedates War

The smaller number of nurses graduated, the greater demand for graduate service (which was due in part to replacing students with graduates and to the general adoption of the eight hour day) and the demand for nurses in industry resulted in such keen competition for nurses' services that many hospitals had difficulty in obtaining enough qualified nurses

even before we were faced with the war. Studies made and published in 1938[1] show that approximately 49 to 55 per cent of the work being done in hospitals by nurses was nonprofessional in character. This indicates the need, even in normal times, for an auxiliary or attendant group. It is uneconomical and undesirable from the standpoint of both the hospital and the nurse to require her to perform routine duties that can be satisfactorily performed by nonprofessional workers.

As has already been stated, the nucleus of registered nurses around which an efficient chronic disease nursing service must be built should consist of individuals who are above the average, as they are all required to be supervisors and teachers. Experience has shown that chronic disease hospitals cannot satisfactorily conduct nursing schools and, as chronic disease patients are not generally cared for in other hospitals, nurses have not received this needed training; nor have the nursing needs of the chronic disease patient been impressed upon them.

What Nurses Need to Know

In the Alameda County institutions, this training is being provided by including in the Highland-Alameda County Hospital school of nursing curriculum "Chronic Medical Nursing and Social Aspects of Senescence." This includes, in addition to instructions in nursing chronic diseases, such subjects as the following: history of geriatrics; significance of increasing life span; premature senility (preventive measures); normal anatomic changes expected in senescence; personality changes to be expected as physiological processes decline; social and economic aspects of senescence; psychological problems involved in nursing; methods of improving patient morale; occupational therapy (selection and guidance, in work and activity); resources available for occupational therapy, recreation and education, and modern trends in meeting the problem.

The students come in rotating groups to Fairmont Hospital, San Leandro, Calif., for a period of six weeks. During this time they are under the immediate direction of a supervising instructor who is a member of both the Highland school of nursing faculty and the Fairmont staff. In addition to classroom instruction in nursing, subjects relative to the care of chronic disease patients and the actual care of these patients on the ward, they are given an understanding of the need for, and an appreciation of the value of, the services of the physical therapist, occupational therapist, medical social worker, chaplain, librarian and school teacher.

These students also spend six weeks under similar conditions at Arroyo Del Valle, Livermore, Calif., with tuberculous patients.

The teaching of these students, and of interns, student dietitians and occupational therapy students, is a stimulus to the entire hospital organization. In order to carry on a teaching program satisfactorily standards must be adopted and lived up to.

Merely providing for training of nurses is not enough to ensure an adequate, efficient staff. Working conditions are made attractive and salaries are commensurate with the type of service required.

The attendant group is made up of those who have been dismissed from nursing schools because of lack of fitness for nursing or for other reasons, graduates of short commercial or correspondence courses and, perhaps the largest percentage, those who drifted into caring for sick members of the family or friends or who needed a job and found such a one in some institution.

Getting and Training Attendants

At Fairmont, we found that it was not possible to obtain satisfactory attendants without training them. Fourteen years ago we established an approved training school and until the present war shortage of help developed, we have not employed any untrained nursing attendants.

The first step in a successful program is the careful selection of personnel. Consideration must be given to personality, health, education and, in general, to all of the qualifications that make up a desirable nurse or other employe. Student applicants to be eligible must have a reasonable background of education. We require that they shall have completed at least two years of high school or have the equivalent in educational experience. Both classroom and ward instruction is given.

The course requires thirteen months (one month's probationary or orientation period, twelve months' regular instruction) and covers systematic instruction in nursing procedures, ethics, general hygiene, elementary anatomy, physiology, materia medica, bacteriology, care and prevention of tuberculosis and fundamentals of nutrition and dietetics. One of the most important phases of the training is the emphasis placed upon certain limitations of the attendant *versus* the graduate nurse.

Both at Fairmont and in other institutions where this type of training is conducted, experience has shown that if a satisfactory course is offered there is no difficulty in obtaining the desired number and type of students. We have also found that if the trained attendant is recognized as having a legitimate place in the organization and is given reasonable working conditions and fair compensation, we are able to select and retain for continued service in our organization an adequate number of the most desirable graduates.

Orderlies Trained on Job

Employing an adequate number of satisfactory orderlies is one of the major difficulties of most superintendents of nurses. This problem is increased in the chronic disease hospital because a larger proportion of orderlies is required than is the case in a general hospital. A large percentage of chronic disease patients, even though more or less helpless, must be assisted in getting out of bed into wheel chairs to be taken to the physical therapy or the occupational therapy department or, most frequently, just out of doors—a simple diversion that means much to the bed-ridden patient.

Many chronic disease patients become very heavy because of enforced inactivity and even on a women's ward orderlies are frequently needed to help lift patients. Orderly service is also required to care for certain types of difficult senile and incontinent male patients.

Nursing does not appeal to very many men. Those who become orderlies are usually motivated by the need for a job and, because of inability to do better, drift into the work as a temporary expedient.

Owing to practical difficulties in the way of getting orderlies to enroll for training courses, however, we

[1]Hospitals, March and April 1938.

are faced with the necessity of training orderlies *on* the job *for* the job which they are doing.

There is no simple solution to the orderly problem, but factors important in obtaining other satisfactory personnel, such as proper evaluation of his position, desirable working conditions and fair compensation, should be given most careful consideration and will help in solving this problem.

Space does not permit a full discussion of all phases of the nursing needs of chronic disease patients, such as the number of patients each nurse or attendant can care for under the various classifications, considering disease, degree of helplessness and services required.

Dr. E. P. Boas in "The Unseen Plague, Chronic Disease" says: "General hospitals allow for about one nurse to every two or three patients. In the hospital section of a hospital for chronic diseases the ratio should be one member of the nursing personnel to every three and one half patients; in the custodial section, one to every six and one half patients. Nursing personnel includes all employes who actually serve patients, *i.e.* graduate and pupil nurses, attendants and orderlies."

Our experience agrees in general with this statement, but we must of necessity allow for fairly wide variation owing to changes in the nursing load as it is affected by the number and degree of convalescents.

"Specials" for Ward Patients

An administrative case history

MORRIS HINENBURG, M.D.
Executive Director, Jewish Hospital, Brooklyn, N. Y.

WHEN a requisition is submitted to the administrator for the assignment of a special nurse for a ward patient, his approval will set in motion the machinery to carry out the terms of the request. The ward patient becomes the free recipient of special services generally denied to other classes of patients unless they are prepared to meet the costs through their own available financial resources.

The administrator, in his evaluation of the request, may approve it on the strength of the information provided on the requisition form, secure in the knowledge that those concerned with its drafting have carefully weighed the facts before arriving at a decision to submit the request.

Protecting the Hospital's Funds

Let us, for the purpose of exploring the reasons for the request, assume that the administrator is unwilling to act before ascertaining personally all of the circumstances that would justify his release of hospital funds for this purpose. Under these circumstances he must be prepared to discuss the consequences of his action (his failure to act on the requisition) with those who are concerned with the welfare of the patient, *i.e.* the relatives, the attending physician and the head of the nursing department.

Explaining Refusal to Relatives

Let us consider the patient and his relatives. Many administrators have had experience with relatives who insist that the hospital provide every service for the patient that may or may not benefit him. It may well be that the patient is on the critical list and requires the most constant and exacting service to turn the tide in his favor. This does not necessarily call for the assignment of a special nurse though in the minds of the relatives there is no other avenue of help for their loved one in the ward bed.

It may even be claimed by them that their inability to meet the costs of special nursing forms the basis for the refusal, if the request is denied. Unable to meet the costs they can only appreciate the threatened welfare of the patient and often remain unwilling to accept the repeated statement that everything that can be done for the patient will gladly be provided for by the hospital in terms of what the doctors and nurses deem essential. In his action of approval the administrator must be convinced that the clinical circumstances are the sole determining factors that prompt the request for special nursing.

To determine the latter the administrator must look for advice to the clinician. He must receive positive assurance that special nursing is necessary (this does not necessarily mean the employment of a special nurse) and that the tearful demands of the relatives have not pulled an assent from his heart strings. Convinced that the clinician is acting solely in the interests of the patient's clinical requirements and through no other influences, the administrator will call upon the superintendent of nurses for the steps to be taken to honor the request.

Part-Time Assignments

If the special nursing services are not required continuously, arrangements may be made for the part-time assignment of a regular staff nurse to enable her to devote her time to this patient and at the same time carry out other duties not in conflict with her special assignment. If the special nursing services are required continuously, it may be possible to readjust nursing schedules for the assignment of staff nurses to the patient. The care of the patient may also be met through the assignment of undergraduate or practical nurses. The superintendent of nurses may, after a careful survey of existing personnel, certify that a special nurse be called whose services will be an added charge to the budget of the hospital.

The method for the treatment of these requests by the administrator is a relatively simple one when the fundamental implications are thoroughly understood by those charged with the care of patients. It is the obligation of the administrator to set up the essential controls for the expenditure of all hospital funds and his authority to obtain the answers to pertinent questions dealing with expenditures in every form remains unassailable, no matter what individual or group in the work of the hospital may challenge it.

And You Think That You Have Trouble

MONICA DICKENS

Charlie was a war casualty, too.

The great granddaughter of Charles Dickens describes war-time problems of a civilian hospital in England where she is serving as a nurse as her war-time job.

THE other day, one of the patients on my ward said to me: "One thing about being in hospital, Nurse, if it wasn't for the wireless and the papers and Mum on visitors' day keeping on about getting home before blackout, you'd hardly know there was a war on."

I suppose this is true, on the surface. A hospital ward is so very much a little enclosed world, with its rules and routine, its personal tragedies and hopes and suffering looming so large that outside events dwindle by comparison.

The patients talk, as patients always have and always will, endlessly about their symptoms. What the doctor said to Sister about Mrs. Smith's x-rays is obviously of more immediate moment than what Anthony Eden said to Molotov about tanks. And if you were Mrs. Jones and had had half your stomach removed, wouldn't you be more interested in your gradual progress from sips of sterile water to cups of milk, to jellies and custards and—joy of joys—a piece of bread and butter than in the progress of the Eighth Army in Italy?

We nurses don't talk much about the war either, on duty. I mean, whether the news is of the retreat from Dunkirk or the entry of our troops into Italy, we've still got to make beds and sweep and dust and get the breakfasts round and the temperatures taken before 8 o'clock, and Heaven help us if Sister arrives before we've finished. Hitler might be dead, but Mrs. Killigrew isn't, though if you don't give her her five minutes' oxygen every quarter of an hour, she soon will be.

A hospital should be a haven. That patient's remark about hardly knowing there was a war on is no testimony to apathy or self-centeredness or isolationism but simply to the success of our deliberate policy. She'd think differently, though, if she could see behind the scenes for hospital life these days is an unending struggle to give peace-time service under war-time conditions.

I'm speaking about civilian hospitals, of course. I don't know about service hospitals, never having worked in one, but I imagine that although there is more drama attached to a ward full of young airmen being brave, a ward full of old lady chronics is just as difficult to run—probably more so.

To start with, we are far busier than we ever were in peace time. Because many have been taken over for the forces, there are fewer civilian hospitals and, of these, whole wards have to be kept empty and ready for emergency casualties. That's our chief difficulty—fewer beds, but more patients. Although, in this fifth year of war, the country is astonishingly well fed, people's resistance to infection is naturally lower than under normal conditions.

Take the case of Charlie, for instance. He was a little back-street shoemaker, always had his go of influenza every winter, stayed in bed for a week with only his nose showing above the blankets and went back to work none the worse for it. But this year it was different.

Two weeks ago, Charlie was up all night firewatching. There were no bombs, but two alerts kept him out of his deck chair, prowling about the draughty top floor of a disused office building in the City. Tired and cold, he went home at dawn and opened up the shop directly after breakfast. Being a patriotic man, he was saving fuel by not having a fire in the workshop, although the windows had never fitted properly since that bomb fell two streets away and made the house shake like a jelly. Halfway through the morning, a customer came and sneezed all over him.

From a B.B.C. Home Service broadcast.

"Nasty cold you've got," says Charlie.

"Ought to be in bed by rights," says the customer proudly, "but they can't spare me up at the factory." And goes off to give his influenza to a few more people. By lunch time Charlie had a headache and a backache, and in the evening he was shivering and sweating by turns. His wife tried to keep him in bed next day. "Can't," says Charlie, "too much work!"

The two other shoemakers in the district had been called up to mend Army boots and Charlie's boy had gone for a sailor right at the beginning of the war. He kept going for three days on gallons of tea and very little food before he collapsed and was brought in to us. We did all we could for him, but we were beaten before he came in. I count Charlie as just as much a war casualty as an airman shot down out of the skies or a sailor torpedoed at sea.

Our hospitals are full of Charlies—people whose influenza has turned to bronchitis and pneumonia, people who go on working when they should be in bed, or who go back to work too soon after being ill. Hurried, irregular meals, too many cigarets and cups of strong coffee and tea to keep a tired body going, these bring us in many more gastric ulcers than in peace time. True, there are fewer neurotic women who manufacture illnesses to fill their idle hours but, on the other hand, the aftermath of the blitz and the anxiety of having sons and husbands in the fight bring us in many more genuine nerve cases.

The chief treatment of nervous diseases is a high fat diet. This means butter, butter and still more butter, cream, rich milk and all the things which, in spite of the help we get from America and the Dominions, have to be drastically rationed. And that brings us to our second hospital problem—food.

Our housekeeping Sister has grown two permanent furrows down the middle of her forehead, one put there by trying to feed the patients, and the other by trying to feed the nurses. Although hospitals get priority and extras, the things that invalids need, like chicken, fish, liver and fruit, are in very short supply, and she must get sick to the screaming-point of having wards ring the kitchen to say they haven't enough milk for the gastric feeds, and will she please not send powdered milk, because Doctor So-and-So won't hear of it.

The doctors have prewar standards. No doubt they're right, but they're hard to live up to when they gaily order a diet of minced liver and raw egg sandwiches for a pernicious anemia. Magically, Sister does it, and still more magical is the way in which she copes with the indecent appetites for which nurses are notorious.

Mine is a voluntary hospital. Whether the voluntary system will be replaced by state control after the war is a question still under debate but, at the moment, we're still dependent on endowments and subscriptions. We've always been short of money and now, with income tax at 10 shillings in the pound, the cost of living gone up, civilian incomes dwindled to service ones—well, you can't expect people to buy War Savings and keep up their full hospital subscriptions, too.

Money is short and the things it has to buy are more expensive, things hospitals need badly, like linen, for instance. It's hateful not to be able to change a sick person's sheets as often as you would like, and we're making do with pillow cases that should have been cleaning rags months ago. The night nurses have to darn like mad in the still watches.

Various drugs and lotions are more expensive and harder to get than in peace time—things like glycerine and methylated spirit, which are needed in the war factories. We used to think that you had to rub a patient's back with spirit to prevent bed sores, but we've now discovered that soap and water and a little extra elbow grease work just as well.

We used to give champagne and brandy medicinally—happy days! But now you've got to be jolly ill before you get brandy, which is kept locked away as carefully as the dangerous drugs.

The Sisters have added more keys to the jingling bunches at their waists, and to get at a rubber hot water bottle or an air-cushion or a pair of rubber gloves is almost as difficult as getting at the Crown jewels.

All rubber goods are as gold and the Sisters know that in a hospital things have a mysterious way of walking from one ward to another. We lost a silver probe the other day. I know everybody thinks that I let it go down the sink, but it seems funny to me that the men's surgical ward suddenly has three probes when they never used to have more than two.

In London night clubs, you buy a bottle of gin or whisky and mark a line on it where you've drunk to

Now elbow grease does just as well.

before you let it go down to the cellar for next time you come. Sister, who's never been to a night club in her life, has taken to doing this with the disinfectant bottles.

Nurses are notoriously wasteful; it comes from having large quantities of everything about. It used to be nothing to put on a 2 gallon urn to make one cup of tea, but we're reforming now. When ever the steam gets shut down at night, if you want to sterilize bowls and instruments you have to boil them up on the stove in great fish kettles.

Then there are staff difficulties. Most of the doctors are either very old and overworked or very young and overworked. It's quite a sight to see some dear, deliberate old buffer of an honorary surgeon, who took his degree before Lister discovered aseptic surgery, doing his rounds of the wards with a sweet young house surgeon tripping behind him who's probably not even through her final exams.

Sister has never been to a night club in her life but still she marks the line on the bottle.

There aren't enough nurses, either. It's only just recently that they've stopped letting all the called-up girls go into factories or the Forces and drafted some of them into hospitals. But though that makes more nurses, it doesn't always work so well.

Nursing's a thing you've got to want desperately to do. You'll never do it well if you're doing it just as a war job, with no more interest in it than whether you're going to get off duty in time to meet those smashing Canadians at the pub round the corner.

Matron's carpet is getting worn quite bare with people waiting on it every morning to be told off. Some of the old-time Victorian Sisters, who trained in the days when hospital discipline and etiquette were even more straight-laced than they are today, are getting shocks that are turning their hair gray under their goffered bonnets.

"These modern nurses! It wasn't so in my day" is a phrase constantly heard. Perhaps it's doing them good, but you can't run an organization like a hospital that deals in life and death without a strict discipline, and some of these modern nurses are pretty feckless. I'm one myself, so I ought to know.

Uniform is an increasing problem. Our lovely full skirts and starched aprons and frilly caps are going the way of all extravagant clothes. The laundries have neither the starch nor the labor to cope with them. At the moment, every hospital still has its distinctive uniform, handed down with scarcely any modification from the days of Florence Nightingale. But they're going to stop all this and put us into "austerity print" dresses and take away our stiff collars and cuffs and belts. I hope it won't sap our morale.

Hospital morale is pretty hard to sap, though. Hospitals kept going all through the Blitz, when the casualties were lying two deep in the corridors and nurses didn't take their uniforms off for days and nights on end and blue-chinned, red-eyed surgeons were operating twelve hours at a stretch in improvised underground theaters.

Even the tame little air raids that London has now cause a certain amount of upheaval. But we must be ready just in case. We may never get a real blitz again, but you never know. The trapped animal is likely to try everything before he finally gives in. But what ever he does try—the hospitals will be ready for him.

Rededication for Service

(Open letter to all hospital workers)

THROUGHOUT the country, at present, one may witness many rededication services almost daily—people from all walks of life and all ages rededicating themselves to their country and its ideals. These services are both tragic and impressive; tragic in that there should be any need for rededication, but impressive in that they are possible at all. For us, in hospital work, there is a great need for this spirit to which laymen so simply and understandingly subscribe.

Whether we are administrators or members of the medical or nursing professions, or whether we belong to that still larger body of clerical and maintenance employes we may still remember that we started hospital work with a definite set of ideals. The wording of those ideals may have differed somewhat, but the basic theme was that of service to the suffering, to the community, to mankind.

Somewhere, somehow down through the years of experience many of us have had those ideals knocked about a bit; some held them above the ordinary, but others allowed them to be "blitzkrieged" by a struggle for recognition or salary.

These are excellent times for us to prove to laymen throughout the country, yes, even throughout the world, that we have ideals worth sacrificing for if necessary.

If we are employes, let's serve. If we are executives, let's lay the foundation for future hospital-community relationships by cooperating with voluntary workers' groups. We can help first-aid classes, canteen groups and sewing groups with suggestions and coordinated experience, but we must never yield to that devilish temptation of letting a volunteer worker slave on the tasks that others have left behind.

So without publicity, quietly and sincerely let's rededicate ourselves to service. Let there be no more show; we all know there is no show in victory, and we're rededicating for victory!—MARY A. SMITH, *administrator, Women's Homeopathic Hospital of Philadelphia.*

NICE PLACE

to work, a hospital— if you make it so

MAXIM POLLAK, M.D.
Medical Director and Superintendent
Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

AS LONG as the financial means at the command of the hospitals are not sufficient to attract workers by the wages they have to offer, hospitals must be prepared to furnish to desirable employes attractions that have a basic human appeal and compensate for low financial remuneration.

By its very location, in the country, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill., is forced to house its personnel on its own grounds. As a part of their salary, therefore, our employes receive full maintenance. However, we do not just furnish them with board and room but provide them with a comfortable home in the true sense of the word.

Our nurses and women employes are housed in a modern building, opened in the fall of 1938. The building consists of two independent units for the two different categories. From the beginning we have taken great care not to discriminate between the two units.

Modern Housing Helps

It is true that we house our nurses in single and the other employes in double rooms, but aside from this differentiation the two units are identical in furnishings and other appointments. This democratic treatment is greatly appreciated by the employes because it recognizes the dignity inherent in every human being, irrespective of social status.

While our male employes are housed in rather antiquated quarters, these are kept in good order and proper repair. In the quarters of all the personnel, both men and women, janitorial and housekeeping services are rendered by a special force. By this simple device not only are cleanliness and proper order assured, but the comfort of the employes is enhanced.

Plenty of Good Food, Too

Food is another item to which we pay great attention. In our sanatorium we have only one menu and patients and personnel alike receive the same meals. Our food is simple but wholesome and appetizingly prepared. To satisfy the greater appetite of the male employes who perform heavy manual labor, they are served for their second helpings with the leftovers of the previous day, which cannot be prevented even with the most economical planning. Thus, they never complain that they don't get enough to eat.

Two weeks' vacation with pay and one week of sick leave per year, the latter cumulative for three years, are provided for each employe. In case of illness, employes are required to be attended by their family physician and are not permitted to return to work until he so advises. Because claims under the workmen's compensation act are due only after one week's disability, the employe is kept on the pay roll for this week and receives his regular salary in case of compensable injury.

A roentgenogram is taken at the expense of the insurance carrier after any fall if the employe complains of pain. Hence, fractures are not neglected and unfounded claims at a later date are prevented. Accidents requiring medical care, except for first aid, are always attended by an outside physician and not by the resident staff, so that the ability to work is determined objectively.

Every member of the personnel is made to feel that he contributes an important share to the patients' welfare and he soon realizes that he is a member of a team engaged in the care of the sick, no matter what type of duties he performs.

The employes are also fully aware of the fact that the door to the administrator's office is always open to them. Here they can air their grievances, real or fancied. Here, too, they can discuss their troubles and worries and receive as much advice and help as a good friend can render.

Because of the type of quarters we have available, we can employ only unattached individuals. We feel, however, that we can offer these a real home. We seek our personnel, therefore, from among a group to which a homelike atmosphere and congenial working conditions are important.

In general, we have always preferred the employment of older and more settled people. Most of our personnel is well over 40 and there is no upper age limit as long as the applicant is hale and hearty and willing to work.

Even under such conditions we have had our share in labor turnover owing partly to enlistments and partly to the allurements of higher wages prevailing on the labor market. We were the hardest hit in this respect in our nursing staff. Here the allurements of continuous employment in the private duty field proved tempting to many younger nurses.

Aides for Routine Duties

We, too, have resorted to the use of nurse's aides whom we train ourselves. In selecting women for this service we have, however, set no educational requirements. While we respect and value highly educational attainments, we still feel that the greatest asset in nursing is the proper attitude and aptitude.

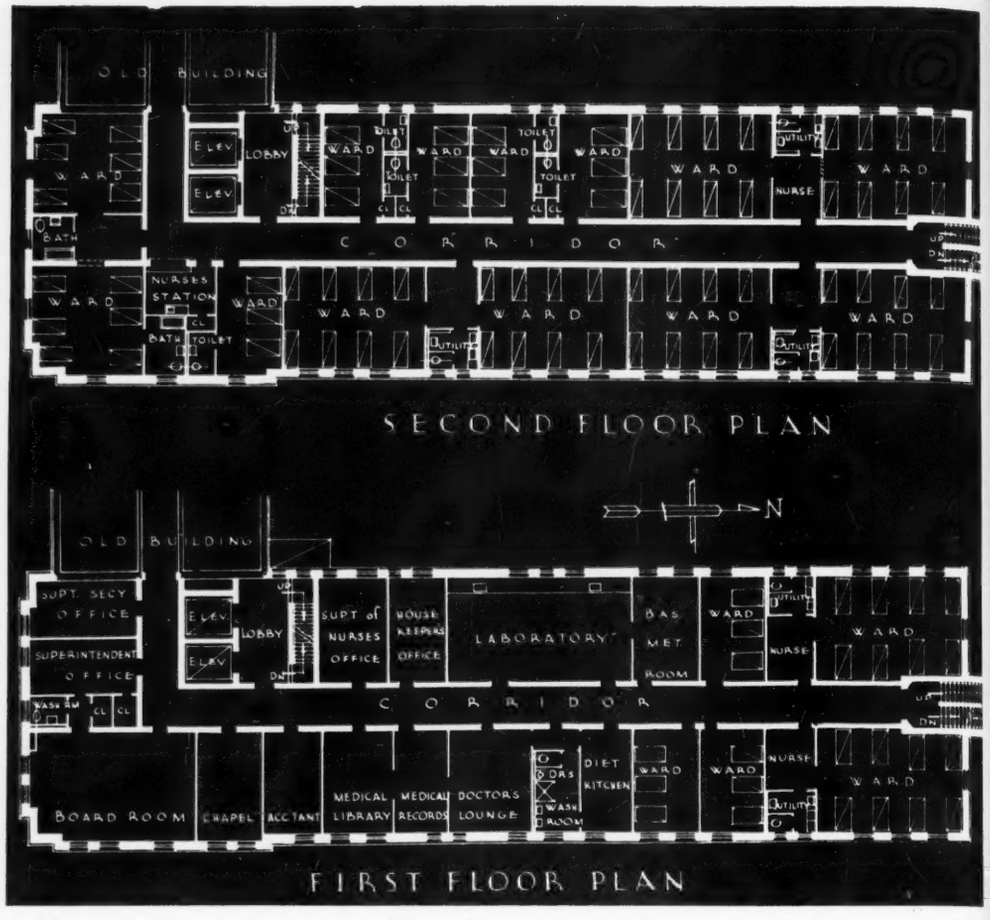
We prefer a nurse with such qualities even if she lacks professional training to the best trained one if to the latter a patient always remains a case and her menial duties are drudgery.

Thus far we have managed, albeit with hard struggle, to provide our patients with all the services essential to their care. What the future will bring remains to be seen.

How to READ FLOOR PLANS

H. ELDRIDGE HANNAFORD

Samuel Hannaford & Sons
Architects
Cincinnati, Ohio



For the convenience of readers, the floor plan on page 68 of the April issue is reproduced.

"YOU see, I just can't read plans." To this statement there is only one reply, namely, "you not only *can* read plans but you *do* read them almost every day."

When you look out of your window and look down on any object you are seeing it in plan. If you recognize what you see, you are "reading plans." Looking down into an open box or a wastebasket gives you the plan of the box's or basket's interior. A floor plan of a building is merely a drawing showing the interior divisions of area on that particular floor and is a true representation of how the floor would appear if it were exposed to view from a position directly over it.

Now what is it that makes plan reading difficult?

Get Right Mental Approach

The answer to that question may be found in the would-be plan reader's mental approach to the problem, which usually conforms to one of the following patterns:

1. The hopeless approach. "A plan is really a sort of code or cipher that can be read only by those with special training."

2. The lazy approach. "Why should I learn to read plans when I can have them explained to me?"

3. The "alibi" approach. "If I don't try to understand plans, and freely admit it, I can never be blamed for any mistakes made, for what do I know about these mysteries?"

If you are in the first or even the second of these groups, you may get something from this article; but if you are in group 3, pass it by.

Look Down From Above

A few years ago I had the opportunity of seeing a building wrecked story by story. My view was from a point several stories above, and almost immediately over, the demolition project. Before the wrecking began my only view of the building was its roof plan, but with the roof's removal, a top floor plan was visible. As each story was taken down the plan of the floor next below appeared until finally I reached the foundation plan when the work ceased.

A floor-by-floor series of aerial photographs of the actual building, for comparison with the original floor plans as drawn, showed an amazing similarity, so, you see, a plan isn't a secret code at all. It is a method of representing on paper how each floor would actually appear if exposed to view from a position directly overhead.

Take as a Textbook—

In the April 1944 number of The Modern Hospital there appear floor plans of two institutions that may be profitably used for initial studies in plan reading. These plans are recommended only for their method of presentation as instruments that graphically portray existing or proposed conditions. No comment is made concerning their merits or demerits as plans.

The plans shown on pages 53 and 55 are presented in the simplest possible form and represent only space assignments, *i.e.* use, of the various rooms and subdivisions on the different floors and yet a clear conception of the layout may be easily obtained by a few minutes' study of each plan and its accompanying legend which, by means of numerical assignments, explain the intended use of each area.

Even though no equipment or furniture is shown, one can easily set up in one's own mind what each floor contains in the way of services, how these services are grouped so as to supplement one another, also how the service units' location will make for efficiency (or the reverse) and soon a definite picture takes shape as one mentally "walks around" on the various floors and through the several departments.

The floor plans on page 68 have been carried one step farther and show such items as plumbing fixtures, counters, sterilizers and beds. These plans are also extremely well presented and should not prove at all difficult to comprehend.

In reading any plan it is helpful to assume a character, say that of a visitor to the institution. Come in (mentally, of course) at the main entrance for the public; step over to the information desk; get on the elevator and ascend to the next floor or to any floor you care to visit. Get off the elevator and go to the floor nurse's station (it ought to be near by) and from there pay the patient a visit in his room.

Then adopt the rôle of a nurse and from this point of view come on duty and start the day's work on your floor, or in the nursery or in the surgery.

If one is really interested in learning to read plans it is easy and interesting. In fact, I often take a busman's holiday and spend hours going over plans and getting a great kick out of it.

Try it, it's not hard, and it's really pretty fair entertainment.

VOLUNTEER ACTIVITIES

The Baker's Contribution

The hospital baker caught the spirit when the ladies' visiting committee of Massachusetts General Hospital, Boston, celebrated its seventy-fifth anniversary recently. In the center of the huge cake bearing the 75 lighted candles was a remarkable sepia painting of the Bulfinch Building, done in cocoa.

At the anniversary tea two members, Mrs. Arthur D. Hill and Mrs. Richard Hale, collaborated on a history and personal reminiscences of the work of the committee. Both have been members for forty years and they had lively recollections of the earlier days.

It's a Sale

Long anticipated among the occasions at the White Elephant Rummage Shop on Ohio Street, Chicago, are the special sales held throughout the year. There have been 16 in the last twelve months: the bathing suit and white shoe sale, the fall hat sale, the Christmas gift and toy sale, a book sale, a spring hat sale, a sports clothes sale and 10 monthly home dressmaker sales.

To obtain stock for this shop, the proceeds from which go to the Children's Memorial Hospital, Chicago, the rummage shop committee holds occasional parties. A movie party, the admission to which was an artistically (or amusingly) trimmed spring hat, was a great success. Last September a games party and fashion show was held and somewhat later the shop celebrated its twenty-fifth anniversary dinner by asking guests to bring silver—hollowware and flatware. These donations, when sold at the shop, after much newspaper publicity, brought high prices for wedding silver no longer in use was brought forth as well as other gifts and trophies which, while they might come under the head of white elephants in one household, might prove highly useful or decorative in another.

Volunteer Social Service

In many New York hospitals volunteer case aides are interviewing patients in the social service department. These volunteers have been graduated from a thirteen week course sponsored by the United Hospital Fund and the North Atlantic district of the American Association of Medical Social Workers. The professional social workers wonder now how they ever got along without them.

From Shopping to Scrubbing

They used to saunter through the wards with a cheerful word here, a bright smile there, an offer to do a bit of shopping or to write a letter home. Their cheerful words and bright smiles come harder now but they come and that's a real tribute to the members of the ladies' board of Free Hospital for Women, Brookline, Mass.

For ward visiting is out for the duration because sterner tasks must be done. Among these tasks are dishwashing, running errands, typing and—yes—even some floor scrubbing.

There is less emphasis, too, on finance as the population in a free hospital naturally has shrunk in these days of universal employment of the employable. Except for a $2000 donation for important research work at the Fearing Laboratory, the ladies' board has underwritten only its annual obligation, including Thanksgiving and Christmas supplies and $300 for social service.

But, no, we are forgetting the new drinking fountain in the operating suite, the new service flag with its 37 stars and the repainting of the nurses' dining room.

We can't forget, however, the ladies' board's voting a bonus of $25 to all members of the hospital family who have worked there ten or more years.

File for Reference

If you are collecting manuals for volunteers preparatory to printing your own, you will by all means want to see a copy of the one recently released by Wesley Memorial Hospital, Chicago. Profusely illustrated with photographs of the most photogenic volunteers on the staff, this 16 page booklet gives a thumbnail history of the hospital and describes the various volunteer groups operating there — Red Cross nurse's aides, Gray Ladies, Victory Volunteers (unaffiliated women interested in helping with office, laboratory and evening clerical work in the nursing stations), American Women's Voluntary Services, Jangos and Men's Volunteer Corps. Follows then a discussion of professional ethics, the volunteer's appearance, special regulations and attendance requirements.

They Take Orders and Like It

When presidents of large corporations spend their evenings making hospital beds, bathing patients, handling oxygen and fracture equipment and the like, that's news. City editors all over the country are dispatching staff photographers and reporters to local hospitals to portray these important men in action in a totally new situation, taking orders rather than giving them, working with their hands rather than their minds and—for the most part—delighting in the work.

A recent issue of the *Pittsburgh Sun-Telegraph* gives a full page to such a story. The readers saw President Lynford A. Keating of the Grogan company filling a fire extinguisher at Shadyside Hospital and S. A. Hartwell, president of the board of Eye and Ear Hospital, putting wires in tonsillectomy snares and wheeling a patient back from the operating room.

Accounting for the Cadet Corps

A. B. ELIAS
Assistant Superintendent
Youngstown Hospital, Youngstown, Ohio

HOSPITALS that are participating in the cadet nurse corps program will do well to keep in mind that supporting records should be kept for all expenditures so that the government can audit the books at some future time, which may not be for several years.

In our bookkeeping the government asks that we keep a separate bank account for its funds; a cash receipts journal and check register to record monies received and disbursed; a general ledger to record postings from the cash receipts journal and check register, and a students' ledger with columns for all items on the approved budget for the purpose of recording under these columns on an account maintained for each cadet the amount expended for each cadet and monies refunded.

In our bookkeeping setup at Youngstown Hospital, Youngstown, Ohio, we have opened a bank account to which all checks received from the government for cadet nurse corps operations are deposited and charged. We have opened a corresponding account to which the other side of the entry is credited and we have termed this account "deferred cadet corps." This account on our general books acts as a cash receipts journal and check register and a summary general ledger as all checks received and checks disbursed are credited and charged to this account.

The support for checks disbursed is figured on our pay-roll system, which has been in use for several years. The pay-roll days, rate and pay are computed on the regular pay-roll recapitulation sheet and the checks are typed on our pay-roll machine, which, in the same operation, types the data on individual earnings cards for each cadet. A check is drawn for the total of this pay roll against the cadet corps bank account and is deposited in our pay-roll bank account; the individual checks are cashed against this account under our system.

For the purpose of computing the other expenditures for each cadet, such as maintenance, tuition and fees and uniforms, we also use the pay-roll recapitulation sheets if they are applicable for that month. These are, in turn, posted on the pay-roll machine to each cadet's earning card.

As a result, we have a complete ledger card for each cadet showing her pay, maintenance, tuition and fees and uniforms. Checks are drawn against the cadet corps bank account and charged to our "deferred cadet corps" account for the monthly total as computed for maintenance, tuition and fees and uniforms.

The procedure advised by the federal government is to take up the "maintenance" and "tuition and fees" as a deduction from expense. Another procedure is to take up the "maintenance" income as income and deduct the "tuition and fees" from expense. Under the federal plan, hospitals will have a reduced per diem cost when this income is taken up and a sharply increased per diem cost when they start to pay $30 per month to senior cadets. Under the second plan, hospitals will have the same variation but will not have quite as large a reduction when taking up only the "tuition and fees" as a credit to expense.

Conservative cost accounting would give us a third and better plan and show us that "tuition and fees" is a proper reduction of expense items, inasmuch as the government is reimbursing us for expenditures involved in getting the cadet started in her training. It would also show us that in order to keep our per diem costs from fluctuating too much, we should take up $15 per month "maintenance" as a reduction of expense and set up the remaining $30 of the total $45 per month "maintenance" allotted to us in a deferred account to which the salary payment of $30 or more per month for senior cadets could be charged later.

If this were done by all hospitals they would not have a deflated per diem cost during one period and an inflated cost later on, and when the government stops the income after the emergency is over they would have the money earmarked to pay the senior cadet pay roll, which will automatically remain to be paid for at least two or three years after that time.

THIS WAY⟶

to Administrative Efficiency

JOSEPH C. GODDEYNE
Architect
Bay City, Mich.

THE attached fragment drawing from a 150 to 200 bed hospital illustrates my conception of an ideal administration department. An explanation of the various offices and their relation to one another is as follows:

The prospective patient is ushered into the admitting office. Two admissions can be entered at the same time and desks and chairs are so provided. When the admission data have been gathered, the patient is directed to the cashier's office and, in case the cashier is busy, the admitting officer can readily enter the cashier's office to receive the check or money on account or can confer with her on other financial arrangements.

Social Service Offices Adjoin

Note that the social service officer can supervise the admission of all patients. In this day of county and state aid necessitating reports, usually within forty-eight hours, of all cases requiring such assistance it is important that the social worker be closely associated with the admitting office and every plan should show these respective offices adjoining and yet opening directly into the lobby.

Pay at Cashier's Wicket

All payments for hospital care are presented at the cashier's wicket. An alcove, in which telephone booths are inconspicuously located, separates the cashier's office from the main lobby, thus ensuring a certain amount of privacy, which would not be possible if the cashier's counter were placed directly in the lobby wall as is the common practice.

If a statement arouses the ire of the patient to whom it is presented and he is inclined to argue vociferously about it, with the possibility of distracting the occupants of the main lobby, the cashier diplomatically requests him to enter the private office where records and explanations can be more intimately discussed and any questionable charges settled in an amicable and businesslike manner.

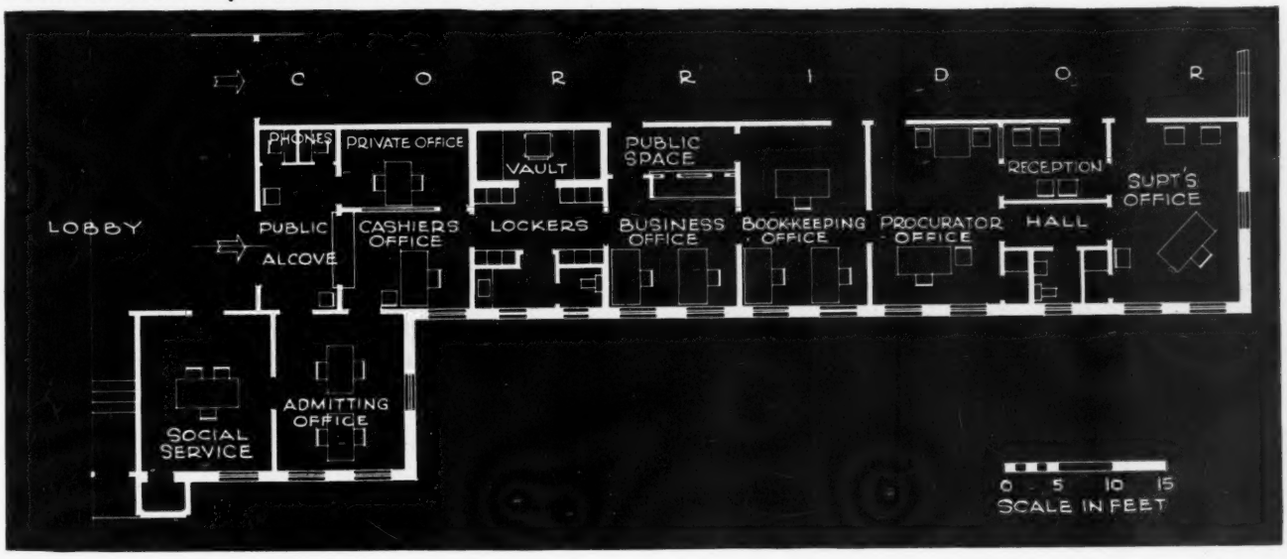
During such interviews the cashier, through a glazed partition, can watch over her office and continue to attend to any calls at her wicket. Patients' bills are usually issued from the cashier's office; about 80 per cent are cash and 20 per cent, on account. Petty cash is usually paid to the cashier.

Vault Is Accessible

A vault is located between the business and cashier's offices in which valuable records are deposited at the end of the day's work. However, if the cashier closes and locks her office the vault can be entered from the business office or, conversely, the business office can be locked up without affecting the cashier's access to the vault. The toilet and locker room are used by the personnel of both the business and cashier's offices.

The business office issues checks to

ADMINISTRATIVE QUARTERS: 150-200 BED HOSPITAL



all employes; pays freight bills and other accounts that are large enough to warrant the writing of checks; reconciles the cashier's accounts, and reports on the expenses and receipts of the hospital. A counter is provided to keep the inquisitive public away from private records and provides valuable and quickly accessible space for files underneath the counter. All paid patient accounts can be kept here.

The counter is equipped with writing ledge and screen with wickets similar to those used in banks. Space is provided for desks with the ends toward the windows so that it is easy to answer inquiries at the counter and makes a natural traffic route from cashier to bookkeeper. There is no waste space, all files are accessible and the personnel can perform its duties without interference.

The bookkeeper's office directly adjoins the business office. Here, the bookkeeper can assemble her accounts and handle the procedure from the business office, and necessary checking and balancing can be performed in quiet without the distraction that is characteristic of the business office where people are going and coming with their interminable inquiries.

The office of the treasurer, who must sign all checks, adjoins that of the bookkeeper. The reception room serves both the treasurer and superintendent because these two officials usually discuss purchases, maintenance and employment together, meet salesmen and frequently consult records and make decisions and enter into contracts in which a mutual understanding and agreement are important.

The superintendent's office is directly connected to the entire department so that he can keep a watchful eye on the daily progress of the institution. It is away from the main lobby so that only inquiries that cannot be answered by the information clerk or cashier or that directly affect the administration will be referred to him.

I feel that this plan of the administration department is efficient; business can be conducted quietly and unobtrusively, yet the department is as well organized as is a vast open accounting room of a modern industrial plant.

Although the principal function of the hospital is to minister to the sick, the business end, nevertheless, is growing more important each day and requires careful consideration and planning.

A Ten Point Plan
for maintaining adequate personnel

KARL P. MEISTER
Superintendent
St. Luke's Methodist Hospital
Cedar Rapids, Iowa

THE many answers to the question of how to maintain adequate professional and nonprofessional personnel during war conditions might be summed up as follows:

1. Adopt refresher courses for those nurses and others who have been inactive in their professions for a number of years.

2. Introduce a federal Training Within Industry course for all employes.

3. Employ part-time help. High school and college students render valuable service.

4. Consider the bonus plan and over-time pay for seasoned and trained personnel; to this add the possibility of pensions and social security.

5. Make use of volunteer help wherever possible and employ a full-time or part-time director of volunteer service in order to utilize this help to the best advantage.

6. Revise methods and plans wherever possible to eliminate duplication and unnecessary time-consuming elements.

7. Employ more labor-saving devices throughout the hospital.

8. Give employment to older and more seasoned people who are not acceptable to war industries.

Bring Up Those Wages

9. Bring the wage to the highest level possible but not in competition with other hospitals in your community or locality. This may mean raising the rates. If so, do it.

10. Do not overlook the postwar program and the necessity for having professional and nonprofessional leaders in hospital organizations—leaders who are able and ready to bring the broken pieces together and mold them into a force that will carry on after the war as well as now. Administrators have slipped into loose and careless methods because of sheer necessity during the war, but the same methods will not work in a postwar world. Neither will the time-worn shoddy schemes of the prewar world be workable. The new plan will require streamlining at every square or rough turn. Now is the time to begin.

If hospitals do begin now, they may know how to maintain adequate professional and nonprofessional personnel when peace comes in a postwar world which bids fair to have as many headaches for hospitals as a war torn world gives them now.

Adequate professional and nonprofessional personnel can be maintained if hospitals, through their trustees and administrators, are willing and able to pay the price.

If I Were a Salesman

WALTER N. LACY
Purchasing Agent, St. Luke's Hospital, Cleveland

IF I were a salesman, what kind of a buyer would I like to find in a hospital purchasing office? Leaving aside the qualifications of good looks and a sweet smile from the woman buyer or the office secretary, and without specifying the brand of cigars used or the color of necktie worn by the men on whom I should call, there are certain things I should like to find in the hospital buyer whom I meet. Here are only ten of these desirable characteristics.

1. **He should not keep me waiting needlessly.** If another caller has preceded me or if an emergency should call for immediate action on the telephone or in another part of the hospital, I would gladly wait. But if he has regular hours during which salesmen can call, I should be seen as promptly as possible if I am observing the schedule. My time is as valuable as that of the purchasing agent and long, unnecessary waiting may take the freshness from my feelings.

2. **I hope for a cordial greeting when I enter his office.** The purchasing agent has his problems, but can he not shove them aside long enough for a cheery "good morning"? It does not help me to have his irritations thrown at me just because I am the first person to cross his threshold or to be blasted with a look that plainly says, "Leave hope behind, all ye that enter here." I might have been able to help him with something but with such a reception I am caught out before I can reach first base.

3. **I should like him to give me a hearing—or tell me frankly but not too bluntly why he will not.** It is true the telephone may interrupt, that is pardonable when the call is incoming. But it does not improve my spirits to have the buyer studying papers on his desk or making notes about something else on his mind while I am trying to tell my story. I should be as brief and to the point as possible and I should be able to sense his interest or lack of interest, but I believe I deserve the courtesy of his attention while I am at his desk.

4. **I want him to be fair.** I do not want him to ask for my prices if he knows in advance that he will not give me the order. I do not want him to use my quotations to pull a competitor's downward. And I do not want him to quote my bid to another salesman—and so I should not ask for the other prices that he may have been quoted.

5. **I want to find the buyer broad-minded.** He may be satisfied with the brand his institution is using, but he should give mine a chance of consideration; he should at least want to learn if mine may not be a better buy without dogmatically rejecting it at once and forever.

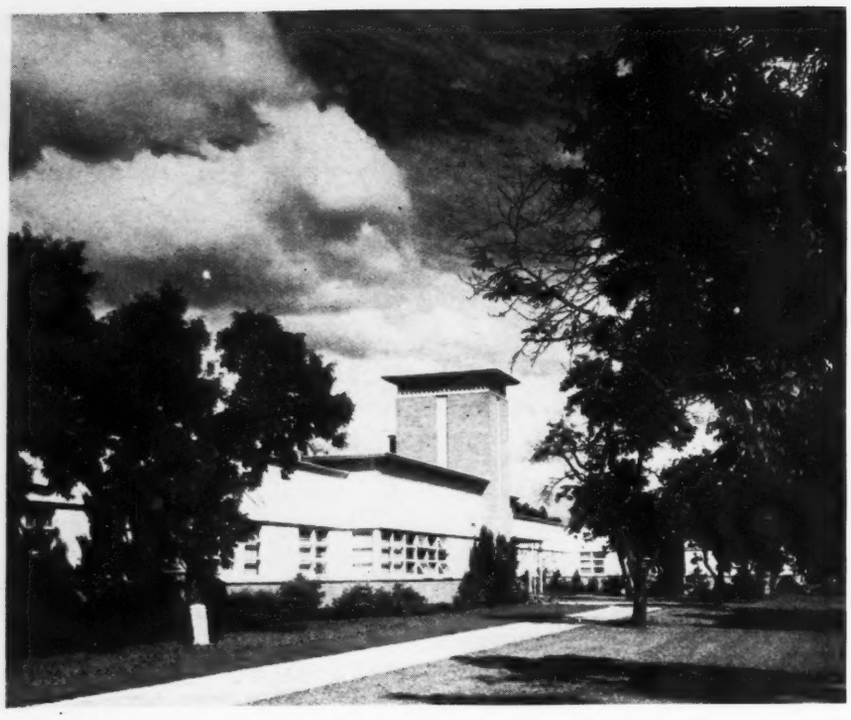
6. **If he rejects my goods I want him to tell me why.** If a competitor has offered a better price, it will not hurt anyone to say so. If he thinks other goods are better in quality or better suited to the needs of his institution, it will help me to know why he thinks so. If his shelves are well stocked on the day of this call, there may be hope of my making a sale the next time.

7. **He should know whereof he speaks.** The purchasing agent should know the terminology and nomenclature used by the trade and not talk in hospital colloquialisms. He should know the commodities he buys and be able to compare what I offer with his previous purchases. He should know how they are used so that he can form a sound opinion as to whether what I offer would be an acceptable substitute. He should know enough about prices to know whether my price is acceptable. And he should know enough to weigh my terms of payment and delivery against those of others. If he does not have all this information in mind, he should have it on file at his finger tips. Otherwise, he may be swindled or I may lose an order I deserve.

8. **I wish he would visit our salesrooms or our manufacturing plant occasionally.** He would understand our problems better if he knew where his supplies came from, how they were produced and how we have to handle them. To do this with all supplies is, of course, impossible, but every plant from which his institution purchases that he can visit is one stone added to his structure for efficient and intelligent purchasing. We shall welcome him at our plant!

9. **He should be untouchable.** If I can influence him to accept my bid by any favors, tickets, luncheons or personal rebates that I may offer him, some other salesman can do likewise. Then my job becomes one of competing as a buyer instead of selling my products on a price, quality or service merit.

10. **Finally, he should have authority.** I want to know that when I accept an order his institution is back of him. If he is only an intermediary who must in turn sell someone else before I can get a *bona fide* order, I may well wonder whether I am in the right office. Of course, I realize that many supplies and equipment items must be considered by department heads, the superintendent or the board of trustees. In that case he will tell me so. How limited his authority may be is not my business. He knows the restrictions under which he must work. All I ask is that he have the authority to represent his institution to whatever extent our negotiations may proceed and that I can depend upon his word.



Exterior, Northern Permanente Foundation that serves the employes of the Kaiser Company.

To Keep the Records Straight

RACHEL FOSTER

Records Librarian, Northern Permanente Foundation, Vancouver, Wash.

ON THE evening that the Northern Permanente Foundation in Vancouver, Wash., was opened for operation there was a meeting of the Oregon Medical Records Librarians at Emanuel Hospital, Portland, just across the Columbia River from Vancouver.

Our hostess for the evening gave an interesting account of the foundation's facilities but reported that she had been unable to find any evidence of a records department in this modern and beautifully equipped institution!

A few days later I made inquiries into the matter and was referred to the superintendent, Frank Stewart. An appointment for an interview was obtained, and the following Monday I found myself in the position of medical records librarian at the foundation with a determination to make the department second to none.

On the opening day the records department consisted of a typewriter, a desk, a chair and four filing cases—a part of the general offices situated between the out-patient and in-patient divisions. With these divisions already under way when I arrived, we immediately began to organize the records unit and make the necessary revisions in chart forms which were on hand. The following organization was evolved:

1. The unit system was adopted.
2. The Standard Classified Nomenclature of Disease was accepted, coding to be done by the librarian.
3. A visible file system was to be installed for a disease and operation index.
4. Charts were to be filed alphabetically, with the patient's shipyard badge number to accompany his name on the chart label.
5. Only in-patient cases were to be indexed.
6. In-patient charts were to be left in the attending physician's office for completion following discharge. Each office was to be supplied with a copy of the standard nomenclature.
7. Indexing was to be done immediately following completion of the record.
8. A hospital discharge and analysis record was to be used.
9. A separate medical secretarial department was to work in cooperation with the records department.
10. Statistical reports were to be compiled by the librarian.

Looking about, I found myself completely surrounded by various departments of the business office—credits, secretarial, accounting, purchasing and personnel. At that time, Permanente consisted of its large out-patient clinic with hospital facilities designed to handle 70 patients.

Originally organized to meet only the needs of the workers in the Kaiser Company's Vancouver shipyard, it soon became evident to our management that the hospital would have to be expanded to furnish medical and hospital care for the wives and children of the workers also. With this in mind, an addition was completed in March 1943 increasing the bed capacity to 225, and a second addition completed in August 1943 raised the capacity to 330 beds.

Matters were a little slow for the first two or three weeks, but by the second month operations in all departments began to accelerate rapidly. The patients poured in and work increased beyond all expectations. A general picture of what occurred in that first hectic fifteen months may be gained by reference to the following tabulation:

Month	*Total Out-Patient Visits*	*Daily Average*
September 1942	509	17
October 1942	2217	72
November 1942	2964	99
December 1942	4894	158
March 1943	8057	260
June 1943	7734	258
September 1943	6250	208
December 1943	11873	383

As the number of patients increased, it became necessary to recruit assistants in my department,

none of whom had had previous experience in medical records work. These were needed for messengers, for filing and typing and one person was taught to do cross-indexing of completed records. From the very beginning lack of ample space has hampered us seriously.

File space was our major "headache," and the records department was shifted about from place to place in the main office, each time overflowing its allotted area. The daily census, as of December 1942, of from 90 to 100 patients in our 70 bed hospital gives an insight into the problems of the foundation.

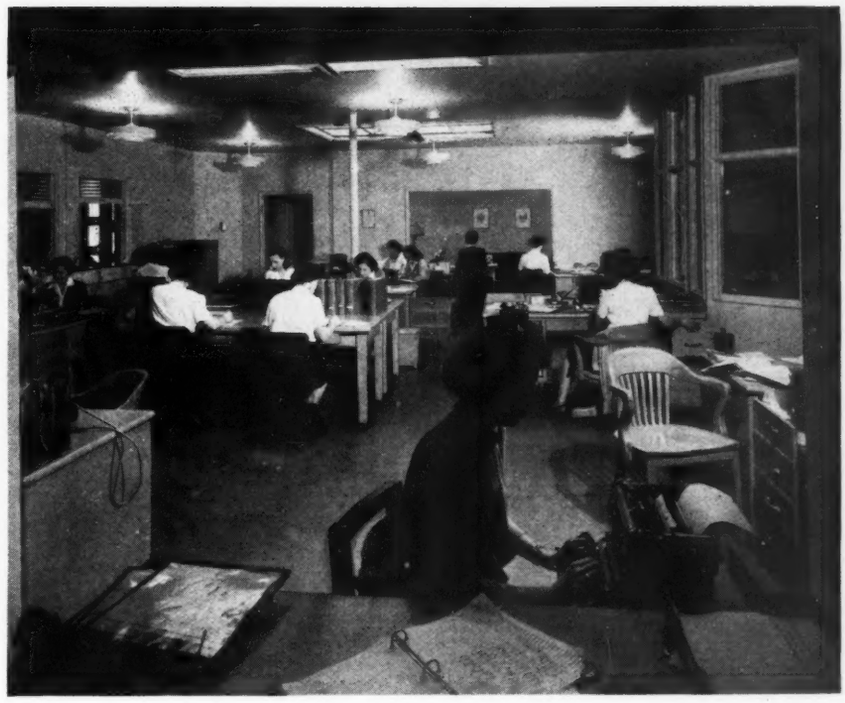
Every corridor of the in-patient unit was lined with beds. Patients were referred to other Vancouver hospitals to be cared for by Permanente staff physicians as long as beds were available, and the out-patient clinic nearly burst its seams.

The space problem was serious in all departments but cooperation was excellent, and as obstacles arose they were readily overcome. The accounting department was the first to be crowded out of the main office and we were again able to exhale for a short time. The purchasing department was next to go and as we looked in on its new quarters down the hallway we anticipated the day when we too might become a specialized unit in our own offices.

In August of 1943 we achieved a degree of privacy for our work when our files were moved into a small room adjacent to the business office. A portion of this room has been lined with built-in shelves on which we store inactive charts. Speed and ease in handling active charts result from the fact that these are stored in our letter-size filing cabinets. Even this room is now crowded, but present plans call for about a hundred per cent increase of our working space in the near future.

So much for the "anatomy" of our own department. We now pass on to its "physiology" in relation to the other phases of Permanente life.

Our general out-patient clinic is split physically in such a manner as to permit its two sections to make joint use of personnel and supply facilities. One side of this clinic is designed for twenty-four hour emergency care and for those patients who can be treated quickly and either sent home or routed to the in-patient section.



Main office: Receptionist's desk in the foreground. Only the corner of the records librarian's desk is visible in this picture.

To the other side are directed those patients who have appointments with a specialist for consultation, careful examination or progress checkups. About a third of the out-patients come in by special appointment, with the remainder drifting in as the mood happens to strike them.

Out-patients are registered by receptionists in both sections of the clinic. Messengers in the records department locate their charts, keep them moving to these desks as needed and return them to the files after patients have been seen and treatment notations made.

With the second addition to our hospital, a smaller out-patient clinic was established at the opposite end of the building from the central out-patient department. Here, specialized

Appointment lounge in the out-patient department. Doctors' offices and examining rooms are on either side of the hall.

OUT-PATIENT DEPARTMENT WORKROOM

services are offered in pediatrics, obstetrics and gynecology for the wives and children of shipyard workers and for women employed in the yard. This second clinic has its own receptionists, file clerks and chart files.

Maintenance of the medical records here is under supervision of the records librarian and all indexing of hospitalized cases on these specialized services is done in the central records department. The pediatrics service uses the unit system and charts are taken by messenger to the general out-patient clinic if the patient appears there for treatment or is referred to some other service.

The obstetrics-gynecology department uses a decentralized system with specialized forms and its hospital and out-patient records are kept in separate files. If one of this department's patients is referred to the general out-patient clinic, another chart is made up and retained in the general clinic files. Records may be transmitted from one clinic to the other for inspection upon request but are readily distinguished by the color of the chart folder—green for obstetrics and gynecology and buff for general out-patient department.

Permanente also operates six outlying treatment locations. Two are at housing project sites for families located three and five miles from the hospital, respectively. If a patient of one of these smaller units is referred to the hospital for specialized treatment, his chart is relayed to the records department. A summary of this chart is entered in the hospital files, after which the chart itself goes back to its point of origin. These charts are sent to and fro in a hospital car which makes hourly trips to the housing medical centers.

The third outlying unit is an infirmary at Hudson House dormitories; the remaining three units are first-aid stations inside the shipyard itself. At these units a simple 5½ by 8½ inch chart folder is prepared for each patient. There is no attempt to incorporate the information at these four locations into the central hospital files unless the attending physician requests that it be done on some particular case.

Permanente has 40 full-time physicians on its staff, with a supporting personnel of nearly 500 persons. We have endeavored to maintain our medical records in the finest condition possible so that they will be available and useful when needed. We find the medical staff and all other employes intensely interested in their work and we are proud to be associated with Permanente's lively organization.

We are anxious to have staff members make use of the files for research purposes and, although a late afternoon request for 100 or 150 cases may disconcert us for a few minutes, we are able to produce them. This type of card provides an incentive to complete cases and operative notes promptly and supplies an added interest and respect for records keeping.

When statistics are requested we are able to provide complete information because our indexing is up to date on all completed cases. In addition to Standard Classified Nomenclature our index lists cases according to whether they are industrial or nonindustrial, contract or private cases. We can locate all the industrial hernias, for example, just as quickly as we can turn to the card in the disease and operation index.

I might mention two general problems encountered in our work which have made it somewhat unusual. Our primary consideration at all times has been the factor of constant growth. In a year and a half we have had to face all the problems connected with expansion that one ordinarily expects to meet in ten or twenty years. Consider the following figures compiled in the period from September 1942 through February 1944. These include only the work done at the hospital proper.

Individuals admitted to hospital out-patient clinics, 38,452.

Total visits to hospital out-patient clinics, 134,512.

Total in-patient admissions, 9641.

Our second major problem in records keeping has been one of personnel. None of my assistants in the department has had previous experience of any sort in this field. In addition to this, the hospital has had to compete for employes with near-by defense industries where wage scales are substantially higher than our own. Our efforts to compete have been only partially successful and personnel turnover has been a difficult problem. Currently, we have 11 persons in our department; two of whom are on swing shift and one is on graveyard shift. Operations are complicated to some extent by the necessity of functioning on a twenty-four hour day and a seven day week.

In spite of everything, Northern Permanente has been able to meet all the requirements for standardization. The medical records department is formulating plans to progress and to produce an even better quality of work for usefulness to the patient, to the hospital and to medical science generally.

How they react to This Business of Rationing

WHILE the food rationing program piles a new pack on already burden-bent backs, the pack isn't as heavy as that being borne by our foot soldiers on the firing fronts.

Small hospital administrators, dietitians and clerical workers sense this and are in no mood to shirk their war responsibilities regarding equitable sharing of the nation's food supplies.

A score of them (20 out of the 50 approached) found time to fill out a purposely simplified questionnaire so that other small hospitals might gain heart and ideas from their experiences in the first year of institutional food rationing. How they react to some of the rationing regulations may be seen in the tabulation in the adjoining column.

Budget for Two Months

Since the food allotment period is two months in duration, most dietitians and administrators find it convenient to budget their ration points over the two months, doing a little mental arithmetic as they go along.

Hospitals are not required by O.P.A. to collect ration points from employes except those who live on the premises seven consecutive days and are served at least eight meals during that period. Yet 25 per cent of the hospitals reporting collect points from employes who eat eight meals in the institution, even though they live outside and another 5 per cent accept ration points on a voluntary basis.

It takes some intelligent handling now and then to get ration books away from employes who live on the premises. Each hospital develops its own method of handling such difficulties. Some administrators put the matter on a patriotic basis, pointing out the necessity for everyone to cooperate in food rationing for the success of the war and to assure an early return of their own servicemen from the battle fronts. Others merely assert that regulations require that the books be turned in and indicate the severe penalty imposed on those who do not comply.

1. **How do you budget ration points?**
   - By two months' period 70%
   - By week 15%
   - By month 10%
   - By day 5%
2. **Do you collect ration points for employes who live outside the hospital?**
   - Do not collect points 70%
   - On voluntary basis 5%
   - Do collect points, if they eat eight meals in hospital 25%
3. **Do you ask incoming patients to bring their ration books with them?**
   - Do not ask them to bring books 60%
   - Ask them to bring books 25%
   - If they stay over two weeks .. 10%
   - Have discontinued practice .. 5%
4. **Do patients usually bring their books with them, when you request such cooperation?**
   - Yes 65%
   - No 16%
5. **Do you serve butter or margarine to your patients?**
   - Butter 85%
   - Margarine occasionally 15%
6. **Do you serve butter or margarine to employes?**
   - Butter 85%
   - Margarine for table occasionally 15%
7. **Do you serve nonrationed foods extensively?**
   - Yes 40%
   - Moderately 20%
   - No 20%

When the hospital has done all it can to obtain a ration book and the employe still refuses to give it up, the hospital has fulfilled its obligation under the regulations and the penalty for wilful violation—a fine of not more than $10,000 or a year's imprisonment or both—falls on the the employe.

If an employe is served more than eight meals but lives in the hospital only six days a week and not seven consecutive days, such a person does not have to turn in his book although, as will be seen, a number of small hospitals collect the books.

Ask for Patients' Books

Of the reporting hospitals 25 per cent make a practice of asking patients to bring their ration books with them when they are admitted, probably not for minor surgery, but for major surgery or other conditions that promise to mean a stay of seven days or longer. Of these some 64 per cent have success with the plan. Sixteen per cent find it doesn't work for them. The remainder says it works in some cases and not in others. Some hospitals have tried the plan but have abandoned it because of poor results.

O.P.A. regulations do not require that a hospital turn away patients who refuse to bring their books. The organization does not wish to deprive any patient of hospitalization but it does expect the hospital to explain to him that it is a mandatory obligation.

Who collects ration books from patients? The dietitian does it in some cases; the admitting desk in others, and a clerical worker from the front office in still others. Nobody mentions adding this burden to the staggering duties of the wartime staff nurse.

(Continued on Page 100)

IDEALS

in the hospital

E. M. BLUESTONE, M.D.
Director
Montefiore Hospital, New York City

THE IDEAL philanthropist is the one who is guided inflexibly by the Golden Rule.

The ideal trustee is the man who practices what he preaches.

The ideal hospital is the one that sees its responsibility to a patient through to the end and is prepared to finish that which it was willing to start.

The ideal hospital administrator is the one who never becomes reconciled to suffering.

The ideal assistant is the one who makes the administrator wonder why he (the administrator) is on the pay roll anyway.

The ideal patient is the one who responds promptly to good treatment and permits you to find out the reason why, if he does not.

The ideal intern is a model of medical politeness in the sense that he will do and say the kindest diagnostic and therapeutic things in the kindest way.

The ideal employe is the one who will never put you in the position where you will have to say no to him.

The ideal volunteer worker is the one who behaves as if she expects her reward in heaven rather than on earth.

The ideal nurse is the one who makes you feel that there is no hurry about convalescence.

The ideal social worker is the one who gives you the warm feeling that your life as an administrator in the hospital is, after all, worth while.

The ideal nutritionist is the one who acts as if the route to a man's brain is the same as the traditional route to his heart. She knows that the human army marches on its stomach.

The ideal surgeon is the one who prefers medical to surgical methods of cure.

The ideal pathologist is the one who has more foresight than hindsight.

The ideal research man differs from the ideal administrator in that the former is always looking for something that he hopes he will find, while the latter is always looking for something that he hopes he won't find.

The ideal dentist is the one who acts as if the loss of a tooth makes you a dental cripple for life.

The ideal x-ray man is the doctor who can see through a patient without the help of the x-ray.

The ideal physical therapist is the doctor who actually contributes to the cure of the patient by the use of physical agents.

The ideal occupational therapist is God's gift to the doctor in his efforts to project cure into the field of rehabilitation.

The ideal visitor is the one who has a contribution to make to the cure of the patient and can do it in no time and with no disturbance.

The ideal accountant is the one who makes you wonder why the profession of auditing was ever born.

The ideal housekeeper is the despair of the exterminating agencies and the delight of the sanitarian.

The ideal purchasing executive is the man who can get it for you wholesale.

The ideal hospital engineer is the one who makes the repair slip an obsolete administrative form of historical interest only.

The ideal personnel executive is the one who does not believe in labor turnover.

The ideal disciplinarian is the one who proceeds on the assumption that unkindness to a patient is a capital offense.

The ideal labor leader is the one who sincerely believes that the comfort of any patient comes before the comfort of any employe.

The ideal clinical conference is the one that has agenda showing no clinical failures that need explaining.

The ideal hospital record is a masterpiece of logic.

The ideal graph of hospital organization is the one that shows every department radiating from and responsible to the patient.

TEAMWORK Is a Time-Saver

FRIEDA CLAUSEN
Laboratory Technician, Charles T. Miller Hospital, St. Paul, Minn.

NOT long ago a group of hospital laboratory medical technologists met at my home for a social evening. Over the coffee cups the conversation turned to "shop talk," as it inevitably will when a group from a single profession gets together. Before the evening was over it had turned into a regular "gripe-session" and I wish you could have heard all the complaints that poured forth in a very few minutes. It started me thinking that maybe something could be done about the situation besides just talking about it, so I am going to record some of the conversation. Please forgive the slang—the girls didn't know they were going "on the air." So, here goes:

"Boy, oh boy, am I dead on my feet," said Mary Anne, stretching out on the davenport with a yawn. "If we get very much more work, and very much less help, I'm going to be deader than a dead cat with all its nine lives extinguished."

"You said it," said Jane. "Honestly there *is* a limit to what a human being can do and I, for one, am fast approaching the limit."

More Work in Less Time

"Well," piped up little Esther, who has more pep and energy than all the rest of us put together, "I know one thing, and that is that I could get twice as much done in half the time if we could get a little more teamwork and cooperation going in our hospital."

"What do you mean, teamwork?" said Mary Anne sitting up and becoming interested.

"Well, cooperation from the rest of the hospital personnel—the nurses and the doctors and everybody. I know they *think* they cooperate, and even try to cooperate, but they honestly don't know some of the things we go through or how much valuable time we waste going through them. I can illustrate my point in about two shakes if each one of you will air one of your 'pet peeves.' I know you all have plenty of them, but one apiece will be enough, thank you."

"Ho, that's easy," said Louise. "Mine is answering unnecessary telephone calls. Do you know that last week I was on alone during the noon hour and I was interrupted 10 times during one differential count, and about half of the calls were on this order:

'NURSE: Could you please give me Mr. Smith's 11 a.m. urine sugar report?

'ME: All the diabetic reports were phoned by 11:30.

'NURSE: Oh, I'm sorry, we've mislaid that report. Could you look it up for me again, please?

'NURSE: May I please have Mrs. Jones' urninalysis report?

'ME: (After spending about five minutes hunting and hunting for either the specimen or the report) I'm sorry, we don't seem to have received a urine specimen on Mrs. Jones today.

'NURSE: Oh, here it is up here; it just hasn't been sent down yet.

'NURSE: Is the crossmatching ready for Mary Brown yet?

'ME: That report was charted over an hour ago. We made a special effort to rush it through since you said the donor was waiting, and we told the nurse at the station that it was ready at the time we charted it.

'NURSE: *(cheerfully)* Oh, yes, here it is on the chart, thank you.

'DOCTOR: Mrs. White is in my office and says she had a metabolism test along about the spring of 1939, or thereabouts. I don't seem to find the report on her card, would you please look it up for me? (Another five minutes without any result.)

'ME: I'm sorry, doctor, I don't seem to have that report.

'DOCTOR: Yes, I remember now she went to another hospital.'

"Ad infinitum. After a series of that sort of thing, my temper is sure raw, and I feel twice as tired from just getting mad and controlling it than if I had really done a job of physical labor."

"Well," groaned Mildred, who is fat, "I know that's bad but I don't mind unnecessary telephone calls as much as all this unnecessary running. Gosh, do I get worn out over all these stat stat orders that dribble in and that mean you drop everything right in the middle and rush up stairs only to find that the patient is in the bathtub, or the patient is in x-ray or the doctor is still in the room and you stand and wait ten minutes to get in.

They're Not Really Stat

"Half of them aren't any more stat than the man in the moon, and you get so you never believe anyone when they want something done right away. Or you haul the metabolism machine way up to the sixth floor (which takes about ten minutes at the rate our elevator runs) only to find the patient has had her breakfast, or been up to the bathroom or is doing a daily dozen when you get into the room. Or someone calls up and orders a complete blood and you get up there with your tray and find the order includes a Wassermann or a Sed. rate and you trot back for more stuff. They must think we carry the whole lab with us on every trip."

"Yes," sighed Helen, "the nurses are bad enough but, oh boy, the doctors. How I could fall for one who really knew what he wanted and said so—and said so *all at once*. Do you know that the other day I had to prick one poor patient four different times because first we got an order for a hemoglobin and later an order for a blood culture, in the afternoon an order for agglutination tests and, finally, about five o'clock, an order for a white and differential count. I felt pretty sorry for the patient but I felt a lot sorrier for myself because of all the time and energy I'd wasted when one trip and

Presented at the meeting of the Minnesota Society of Medical Technologists, May 1944.

one prick would have taken care of it all."

"And not only that," retorted Mary Anne, now thoroughly awake. "but you're expected to have the imagination and insight of a clairvoyant. Only last week a patient came in and cheerfully said she was to have a blood test. 'A blood test,' said I sweetly, 'what kind of a blood test?' 'Oh, she said, 'the doctor just said I should stop in at the hospital some time and get a blood test. I believe he said a blood count.' (Big help—there being only about 10 different kinds of blood counts.)

"So, I sat her down and started telephoning the doctor's office, but the office girl didn't know any more than the patient. Of course, you know that finding a doctor in the middle of the morning is like finding a needle in a haystack. Oh, yes, I got him in half an hour or so and got the order O.K., but only after wasting many precious moments which might have been used to better advantage.

"And then again, we get orders like this—agglutination tests. (There are about 10 different kinds. Does the doctor want them all or only one or three or five of them?) Orders for sputum examination. (Does that mean a routine exam, culture for strep, culture for fungi, smear and culture for T.B., guinea pig inoculation or pneumo typing?) Or an order for a stool culture. (Is he interested in cultures for strep or typhoid or dysentery?)

"All these various procedures are different and would often involve unnecessary expense for the patient *and* unnecessary work for us. So we have to begin telephoning, first the nurse, then the intern and, finally, the doctor to find out what he really wants done. More time wasted."

"I for one," spoke up Agnes, "envy the hospitals that require all blood chemistry orders to be in by 8 a.m. After all, it is only a habit, for the majority of chemistries, with a few exceptions, can be ordered the day before, and at least half of them should be fasting anyway. But I trot and trot, getting one at a time all day long. I could get 10 times the work done in half the time if I could only get them all at once the first thing in the morning. Lots of hospitals have tried it and found it worked very well to have a rule like that, but in our hospital it just isn't done that way."

The conversation went on and on along these lines until finally Esther burst out laughing. "Boy, did I start something when I asked you to air your complaints. They certainly illustrate my point about cooperation and teamwork very nicely. Do you girls realize that if this were a group of nurses, or dietitians or pharmacists gathered together, they could probably all bring out just as many complaints about us? We probably waste their time, too, and don't know it. We're not so darn perfect. And if we were told, maybe we could get busy and do something about it."

"Say, you've really got something there," said Jane. "The thing is how to get together on this teamwork business. Wouldn't it be swell if we could help save their time, too. Goodness knows I guess they're worse off than we are."

"Why not start a Clearing House for Complaints," said Mary Anne. "Maybe it could be done by periodic meetings of heads of departments. Or by occasional bulletins typed and passed around to departments or posted on the bulletin board. The bulletins might be headed 'This Is How You Can Help Save Our Time and Energy. How Can We Help Save Yours?'"

"Yes, but how are you going to ring the doctors in on that idea?" said Helen. "As we've pointed out they're often the worst offenders and they *don't* like to be told."

That stumped us all for a few minutes. Even Esther who really started this whole thing didn't have anything to say for awhile but finally spoke up. "They may not like to be told," she said thoughtfully, "but they're all pretty darn nice and open to suggestions and willing to cooperate when they're asked. The difficult question would be how and when and where to present the ideas we want to get across. That's something to think about. Maybe our hospital superintendent and pathologist would have some bright ideas on the subject if we asked them. After all, it's certainly in *their* interest to help us save time. And I'm pretty sure we wouldn't have much difficulty in proving that 'Teamwork Is a Time-saver.'"

A Helping Hand

PARADOXICALLY enough, hospitals progress under the stimulus of adversity. Despite our woeful sentiments about the wartime lack of help, trained and untrained, we may depend upon it that history will repeat itself and we shall again come into our rightful heritage when peace returns.

We must explore all possible sources to obtain workers for our hospitals and be more resourceful than ever as we go along. Cooperation among hospitals is important in peace time, but it is urgent in war time. A hospital employment exchange was never needed more badly.

Those of us who were in England during the "blitz" period of its history were fortunate in the opportunity of witnessing a cooperative response. Everybody pitched in calmly and lent a helping hand where it was most urgently needed.

The helping hands were provided in part by ambulatory patients, many of whom were maimed heroes of the memorable battle of Dunkirk. These boys helped to make beds, sweep floors, wash dishes, hand bedpans to their sicker comrades and they cheerfully performed any task that was assigned to them. It would seem from this experience that we should organize our defense better and go so far as to obtain the assistance of ambulatory and convalescent patients for war-time needs.

There are many ways in which we can share our burdens and lighten our load. Some of these ways are obvious while others remain in obscurity till someone appears to shed light in dark corners. The strong have always helped the weak, and this is a matter of degree. There is strength in a hospital employment exchange and there is strength, too, in an organization that makes full use of available physical power, however handicapped.—JOHN F. CRANE, *assistant director, Montefiore Hospital, New York City.*

It Keeps Them Entertained

INCLUDED in the medical and surgical care the Navy gives to wounded sailors at St. Albans Naval Hospital, St. Albans, N. Y., is ten hours a day of entertainment over the hospital sound system.

When a man has been wounded at Tarawa or Salerno or on any other of our far-flung battlefronts, he can't read all the time while he waits in the hospital for his injuries to heal. He can't play checkers all the time, either. But days pass quickly if he has music, radio variety programs, news broadcasts and football or baseball games to listen to.

St. Albans Naval Hospital, Capt. Lester L. Pratt, commanding, gives every patient this varied program through a hospital-wide sound system, controlled and operated by naval personnel. Wave Ensign Emilie Placatka, the program director, confers with her audience before setting up every new schedule of recordings, concerts by the station band and radio programs.

Tops with them are musical request programs of which they get at least an hour daily. Several popular news commentators run a close second, but "no Sinatra, please," say the patients.

This morale equipment was donated by the National Council of Jewish Women.

Above: Staff Talent. The hospital band, with a Wave to handle the big bass, swings into a bit of jive broadcast over the sound system. Below, left: The program director picks out the patients' first choice for the daily recorded variety hour while Lucille Ingebretson, pharmacist second class, monitors the control cabinet. Below, right: This trio of ward patients sits under the loud-speaker so as not to miss the big news.

Let's Be Dignified

in Promoting the Blue Cross

CHARLES A. LINDQUIST
Managing Officer
Sherman Hospital, Elgin, Ill.

HOSPITALS have set up high standards in connection with the administration of the Blue Cross plans and one of them is that the promotion of the plans must be dignified and ethical and in harmony with the ideals and ethics of the medical and hospital professions. This dignity has not always been evident in the promotion or publicity programs of some of our plans, which is to be regretted.

Too often promotion of a plan has taken precedence over sound underwriting, good judgment or proper hospital relations, a procedure which, if not carefully guarded against, may lead to disaster rather than to the success desired. It is quite all right to be progressive, to nullify as far as possible the encroachment of commercial plans and to minimize social security expansion, but dignity and good judgment in these goals should be maintained for the benefit of all concerned.

Plans Represent the Hospital

Before any real program of hospital sponsorship can be successfully inaugurated there must be a complete realization on the part of the plan organizations involved that they are the direct representatives of the hospital, that according to the rules as we interpret them, laid down by the Hospital Plan Commission of the A.H.A., the hospital in most instances becomes the insurer and guarantor.

The hospitals must have complete confidence in their respective plans in order that they, in turn, may give enthusiastic cooperation to these plans. Merely to desire this cooperation or request it is not enough. It must come through attitudes of friendliness and cooperation on the part of both hospital and plan employes.

The personnel of Sherman Hospital, Elgin, Ill., has become so thoroughly steeped in Blue Cross hospitalization that each individual knows the contracts and the entire procedure to its last detail. We have tried to see that our people thoroughly understand each step in order that their explanations to the inquiring public may be clear.

On the other hand, we have always felt perfectly free to call the plans whenever we needed information and, in most instances, have had the fullest cooperation. In this manner we have established basic psychological and fundamental business relationships which we feel have been mutually beneficial.

At the present time we are serving many different Blue Cross plans, several within our own state. They all have their advantages and disadvantages. In this connection there is a point that I believe should be brought out. It is the problem of benefit coverage. Some plans pay anywhere from $5 to $8 per day, some cover one thing and some cover another. It is, to say the least, confusing and when two patients start discussing the merits of their own individual contracts, some plan is bound to be criticized severely. It would seem advisable for the Hospital Service Plan Commission to coordinate and possibly merge several small plans into a state-wide organization so as to bring about more uniform rates and benefits.

Once these basic foundations between hospitals and plans are established and a workable plan is accepted, consideration can be given to the type of publicity or advertising that should be used properly to promote the welfare of both. All forms of literature or publicity should be dignified and ethical and in accordance with our codes as we have always understood them.

We should not have to appeal to the child mind to sell the idea of the Blue Cross plan. This is an insult to the intelligence of the average individual. However, this sort of publicity has crept into the picture, in some isolated cases, in some of our promotional plans and should be discouraged. It has not been helpful to our hospitals in their public relationships.

Today, one well-worked out piece of literature that is simple and dignified is worth a dozen of those that border too much on the humorous side. Newspaper publicity should in all instances emphasize service and the build-up should always include the hospital's part in the plan. Member hospitals should feature in their publicity what the plans and the hospital together are doing for their communities and by so doing they will develop a much better hospital-plan relationship than that followed by most institutions in their publicity.

Literature Is Distributed

Another phase of publicity is the distribution of literature in connection with Blue Cross plans. We have distributed much of this from time to time. We have kept stacks of it at our outer office and in our lobby and doctors' rooms and we have mailed pamphlets out with our statements. Lately we have not done much in the way of distribution of literature, possibly because we have not had as much to hand out, but we do give pamphlets to our own employes, who are enrolled four times a year and are given literature at the times of enrollment.

Our employes are all members of the plan and we feel that this is necessary for both the hospital and the employe. As a result, our employes have all become potential salesmen for the plan and tell the story of the Blue Cross wherever they go, which, after all, is the best kind of publicity.

Possibly because we are a community hospital, we have become the information bureau on Blue Cross plans. We have tried to act as a connecting link between the prospect and the Blue Cross plan itself. We feel that we have succeeded. We ourselves are sold on the Blue Cross and for that reason it has not been hard to sell others.

From a paper presented at the Tri-State Hospital Assembly, May 1944.

About People

Administrators

S. Chester Fazio has been appointed superintendent of St. John's Riverside Hospital, Yonkers, N. Y., succeeding the late **Capt. Harry Warfield.** Mr. Fazio formerly was superintendent of Easton Hospital, Easton, Pa., and prior to that was superintendent of Rockaway Beach Hospital, Rockaway Beach, N. Y.

Myron S. Burton has resigned as superintendent of Sheboygan Memorial Hospital, Sheboygan, Wis.

Josephine Dorsey, R.N., has been named superintendent of Doctors Hospital, Omaha, Neb., succeeding **Thomas J. Nuckolls,** who has left to take a course in hospital administration in New York. **Marian Garvey, R.N.,** has been appointed assistant superintendent.

Lester Reid, who was formerly auditor at Presbyterian Hospital, Chicago, and more recently comptroller of Albany Hospital, Albany, N. Y., returned to Presbyterian Hospital on July 1 in the capacity of assistant superintendent.

Rev. John G. Martin was recently awarded the degree of Doctor of Sacred Theology by the General Theological Seminary, New York City, of which he is a graduate. The Rev. Mr. Martin is superintendent of the Hospital of St. Barnabas and for Women and Children, Newark, N. J., and also president of the American Protestant Hospital Association. The degree was conferred upon Mr. Martin in recognition of his outstanding service and achievement in the hospital field.

Adeline Hawxhurst has been appointed superintendent of Indiana Hospital, Indiana, Pa., succeeding **Lillian Hollohan,** who resigned March 1 because of ill health. Miss Hawxhurst has been associated with the hospital since its founding and became acting superintendent when it became necessary for Miss Hollohan to take a leave of absence. Prior to that Miss Hawxhurst had been assistant superintendent.

Elizabeth McKay retired on June 30 as administrator of Kauikeolani Children's Hospital, Honolulu, T. H., after serving in that capacity for seventeen years.

Paul J. Spencer, assistant to the director of Butler Hospital, Providence, R. I., has been appointed secretary of the New England Hospital Assembly. Mr. Spencer succeeds **Gerhard Hartman,** administrator of Newton Hospital, Newton Lower Falls, Mass., in this position.

Dr. Harry P. Thomas has been selected as medical director of the Woodmen of the World War Memorial Hospital, San Antonio, Tex. He succeeds **Dr. Augustus D. Cloyd Sr.,** medical director of the Woodmen of the World, who has been acting superintendent for several months.

Adelia Meihlisen has been named to succeed **Dorothy Brossia** as superintendent of Monroe Hospital, Monroe, Mich.

Robert R. Stewart, assistant superintendent of Lucas County General Hospital, Toledo, Ohio, has been named head of the institution, succeeding **R. E. Gregg.** Mr. Stewart was formerly assistant superintendent at Toledo Hospital.

Department Heads

Anna T. Lownie, R.N., reported on July 1 to the Menninger Sanitarium, Topeka, Kan., where she will occupy the position of assistant superintendent of nurses and assistant director of nurse training. From October 1941 to December 1943 Miss Lownie was assistant superintendent of nurses at New Jersey State Hospital, Greystone Park, N. J. She received her master's degree from Teachers College, Columbia University, in June 1944.

Frances V. Brink has been appointed director of nursing and principal of the school of nursing at Children's Memorial Hospital, Chicago. Miss Brink is a graduate of Philadelphia General Hospital School of Nursing and for the last thirteen years has been superintendent of nurses and principal of the school of nursing at Milwaukee County Hospital, Wauwatosa, Wis.

Mrs. Olive MacLean Northwood, director of nursing and principal of the school of nursing at Queen's Hospital, Honolulu, T. H., will relinquish her duties on September 1. She will be succeeded by **Margery MacLachlan,** who went to the Islands in 1943 to serve as hospital consultant and director of nursing services for O.C.D. emergency hospitals throughout the Territory of Hawaii.

Miscellaneous

Dr. Hugo V. Hullerman and **Hazen Dick** have been named secretaries of the American Hospital Association Council on Professional Practice and Council on Administrative Practice, respectively. Until his resignation to assume his new duties Doctor Hullerman was chief of the division of maternal and child hygiene of the Illinois State Department of Health. Prior to joining the A.H.A. staff Mr. Dick had been administrator of the Louisville General Hospital, Louisville, Ky., and of Waverly Hills Sanatorium, Waverly Hills, Ky.

Sallie Mernin has resigned her position as assistant director of the U. S. Cadet Nurse Corps to resume her duties as assistant professor of nursing education at the University of Chicago. **Helen Schwarz,** whose appointment as nurse education consultant was announced last month, has succeeded Miss Mernin as assistant director.

W. S. Brines, chief of the hospital section, W.P.B., has been appointed to the advisory panel of the Office of Civilian Penicillin Distribution.

Deaths

Dr. Joelle C. Hiebert, superintendent of Central Maine General Hospital, Lewiston, Me., since 1931, died June 8. Doctor Hiebert, who was a graduate of Boston University School of Medicine, was clinical instructor in obstetrics, Boston University, from 1924 to 1931 and instructor in preventive medicine and first aid at Gordon College School of Theology and Missions, Boston, from 1929 to 1931. He was a member of the American College of Hospital Administrators, American Hospital Association, American Protestant Hospital Association, New England Hospital Assembly and Maine Hospital Association. He served as president of the New England assembly in 1941-42 and of the Maine organization in 1937-38.

Gladys Hills, at one time head of the food clinic of the out-patient department of Presbyterian Hospital, New York City, and more recently nutritionist for the Greenwich Tuberculosis and Health Association, Greenwich, Conn., died in that city. Miss Hills had been active in the affairs of the American Dietetic Association and other professional groups.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

In the event of INFLATION

E. W. AXE
E. W. Axe and Company, Inc.
Investment Counsel, New York City

CAN hospital finance committees protect themselves against the evil consequences of inflationary advances in the general price level if and when this develops? This is a question that deserves careful consideration.

Improved efficiency and larger endowments, desirable as they may be, do not offer a full solution of the problem. If the difficulty can be met at all, it is only through the effective handling of hospital investments.

In a period of stable business and financial conditions the safest type of investment for a hospital to hold is high grade, long-term bonds and mortgages. Under normal conditions such securities supply a reasonable income, and their dollar value is unlikely to change greatly. They are almost as safe as cash.

No Chance Against Inflation

Precisely because they are so closely similar to cash, however, they offer no hope of protection against an inflationary advance in prices. If the general level of prices doubles, a dollar will buy half as much, and both the capital value and the income of a hospital fund invested in high grade bonds will be worth half as much, measured in the power to purchase goods and services. Thus, we cannot look for help from high grade bonds and mortgages.

To obtain some protection against inflation we must own property that has a possibility of advancing in dollar value as the general price level advances. As a practical matter there are three such forms of investment open to hospital funds: (1) commodities, (2) real estate and (3) securities other than high grade bonds or mortgages. We shall discuss these three possibilities briefly.

A hospital might select a small number of commodities that seemed likely to rise as much or more than prices in general and invest part of its funds in these commodities. Staple raw materials would be the most suitable for this purpose because in the past prices of such commodities have usually moved more widely than has the average of all commodities. Raw cotton, grain, nonferrous metals or leather might be employed for such a purpose. It is probable that a selection of commodities of this sort would, in fact, give reasonable protection.

However, there are obvious and serious disadvantages. Investments of this type would bring in no income. On the contrary it would cost something to store and insure the commodities. If held for a long time some commodities would deteriorate. Under present conditions and perhaps in the future the holding of some commodities for this purpose might be regarded as hoarding. Markets for many commodities are less satisfactory than those for securities and some fractional loss would result from buying and selling.

Although some of these difficulties might be avoided by the purchase of commodity futures, such a plan would involve other and dangerous disadvantages. We must conclude, therefore, that, except under unusual circumstances, investment in a selection of commodities is not a good solution.

The investment of part of a hospital fund in real estate offers a somewhat more promising form of inflation offset. A substantial advance in the general price level would certainly result sooner or later in a rise in real estate prices and rentals. The disadvantages of this form, from an investment standpoint, are pretty well known to all hospital finance committees.

The location of the particular pieces of real estate purchased is of great importance and there is always the danger that because of local circumstances an advance in general real estate prices may fail to bring about a rise in the particular parcels held. Upkeep and depreciation are always high and easy to underestimate. Tax rates may change unfavorably, buying and selling involves substantial commissions and markets are thin and unreliable.

Finally, real estate prices often lag substantially behind general commodity prices so that it would be easily possible for an interval of several years to elapse in which real estate would be of little value for inflation hedge purposes.

In spite of these difficulties it would seem that some part of a hospital fund might reasonably be invested in real estate, if it could be selected expertly and bought at low prices. It is obvious, however, that an investment of all of a hospital fund in such property would be unsound.

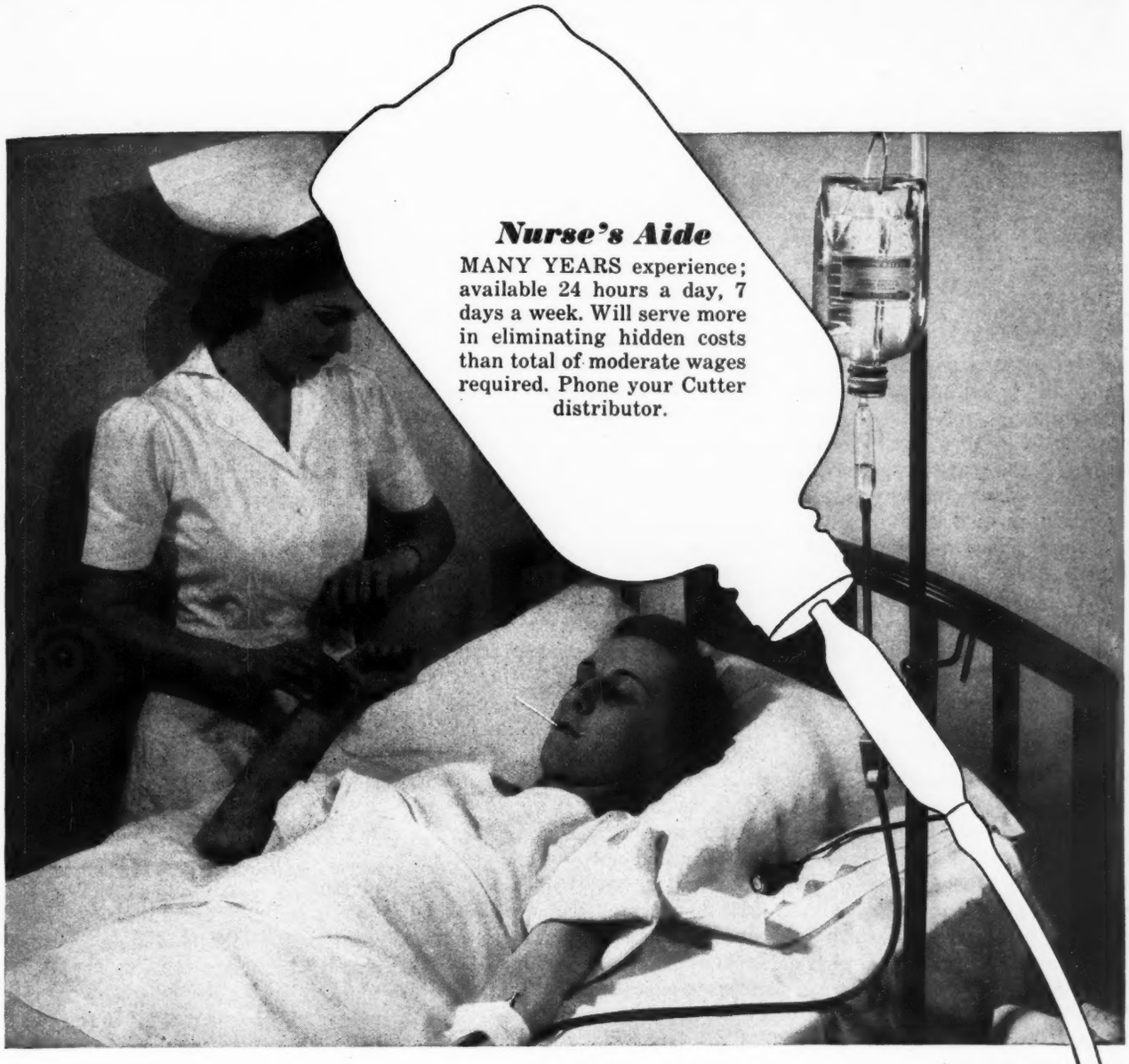
Less Than High Grade Bonds

The third and last possibility is investment in securities other than high grade bonds. Some bonds of less than high grade might be useful for this purpose but for the most part the investment would necessarily be in common stocks.

Common stocks have, in general, tended to rise in value in periods in the past when commodity prices have risen, both in this country and in foreign countries. In the French and German inflations of the 1920's, holders of common stocks fared much better than the holders of bonds or cash, as indicated by the table on the following page.

Although the situation in this country is quite different from that in France and Germany and although any inflation here will probably be less severe, it is interesting to observe that even with conditions so unfavorable as those that prevailed in France and Germany, common stocks gave a good account of themselves.

It is sometimes argued that a rise in the general price level will not



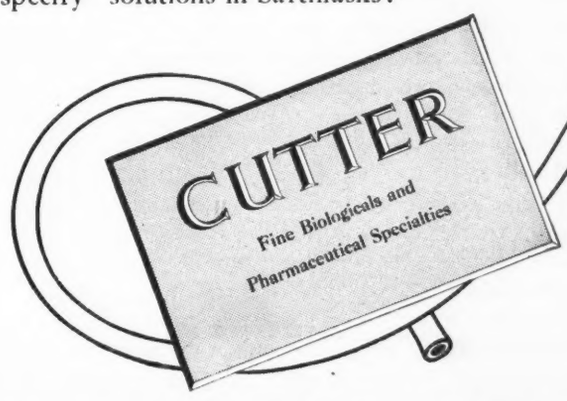
It's the time-saving, temper-saving, life-saving CUTTER SAFTIFLASK!

With nurses and doctors both working double time these days—there's more need than ever for the smooth, trouble-free performance of Cutter Saftiflasks!

No loose parts to wash and sterilize. No tricky gadgets to go wrong in the crisis! Just plug in your injection tubing.

You'll find the steady, adjustable flow is as dependable as the solutions themselves — solutions tested in every conceivable way, with the infinite care of a biological laboratory.

It's just as easy — and so very sensible — to specify "solutions in Saftiflasks!"



CUTTER LABORATORIES • BERKELEY • CHICAGO • NEW YORK

Gold Values of German Stocks and Currency and of French Stocks, Bonds and Currency (January 1919=100)

January	*German Stocks*	*German Marks*	*French Stocks*	*French Bonds*	*French Francs*
1920	22	14	56	44	46
1921	36	13	37	31	35
1922	33	4	43	39	45
1923	10	0	47	33	36
1924	72	0	46	21	26
1925	74	0	50	21	29
1926			37	14	21
1927			49	17	22
1928			62	20	21

result in a corresponding rise in earnings of American corporations. An examination of this position, however, shows that it is logically unsound. If prices rise, let us say, to a level four times the present one and if the earnings in dollars of American business as a whole remain unchanged, that will mean that the return on the invested capital, measured in dollars (which of course will be four times as much figured at the new price level), will be cut to a fourth of the former rate.

Return Rate on Capital Raised

Such a rate of return would attract little new capital and, in consequence, the supply of plant and equipment would shrink. This would tend to raise the rate of return on capital. In any case, to assume that, in a world in which so much plant and equipment have been destroyed and used up by war, the rate of return on capital equipment will shrink substantially is, on its face, unreasonable.

It is argued at times that productive capacity has been greatly increased during the war and that production per capita will be much greater after the close of the war and that this will hold prices down. Actually, it is the capacity to produce war materials that has been expanded while capacity to produce the types of goods ordinarily used in peace has contracted.

Supplies of many raw materials will remain short for a number of years after the close of the war just as they did following the last war. It will take time to restore our production of many types of peace goods to normal levels. Taking the world as a whole, we cannot doubt that the net effect of the war has been to destroy capital equipment rather than to create it. This is certain to have an effect upon the supply of goods. But even an increase in per capita production would not necessarily prevent a rise in the general price level.

We have mentioned that some groups of common stocks are ill adapted and others well adapted to inflation conditions. In general, industries in which selling prices are fixed by law or custom are likely to have a hard time during a period of rising prices because their costs will advance and their selling prices will not or, if they do, will rise slowly.

Utility and railroad industries are both in this position. If the general price level rises substantially, material costs and, far more important, wage costs will rise while rates can be readjusted only with great difficulty and delay. Under such circumstances profit margins would contract. So a substantial rise in the general price level would have an adverse effect upon securities in these two industries.

It is true that this unfavorable factor might be offset by other developments. For example, if business is very active and if taxes are greatly reduced, the railroads might still be able to make good earnings. But, by itself, a rise in prices would be a depressant.

On the other hand, companies producing raw materials or normally carrying large inventories of raw materials would be likely to do exceptionally well. In the past, because of the length of the process of production, leather companies have had to carry large inventories and a rise in the price of hides has resulted in sensationally large profits.

Companies producing crude oil would probably benefit a great deal from inflation because it is possible that crude oil prices would rise much more rapidly than costs. Earnings in the general run of manufacturing companies would probably just about keep pace with the rise in the general price level.

In some cases prices would rise promptly and in other cases with a lag and this would cause temporary expansions or contractions in earning power, but within a few years after the new price level had been reached it is likely that these differences would be pretty well ironed out.

During a period of rapid advances in the general price level, inflation would not be the only influence affecting the value of different groups of common stocks. Allowance would have to be made for other factors, as is always the case with security investment, and no set formula could be applied in a mechanical way.

Some raw materials, for example, may be in a poor position after the close of the war, as copper was in the early 1920's, because of conditions particular to the industry. The effect of war-accumulated shortages and surpluses on different industries, new technological developments and many other factors will have to be taken into account in managing any hospital investment fund.

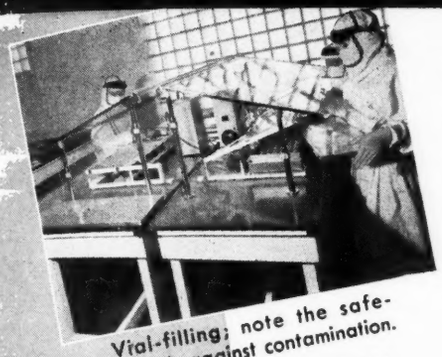
Funds Can Be Protected

An effort to protect a hospital investment fund against deterioration in purchasing power resulting from inflation seems to stand a much better chance of success in this country under present conditions than it would have in France or Germany after the close of the last war. Although the war has produced serious economic dislocations, the country has escaped important destruction by enemy action.

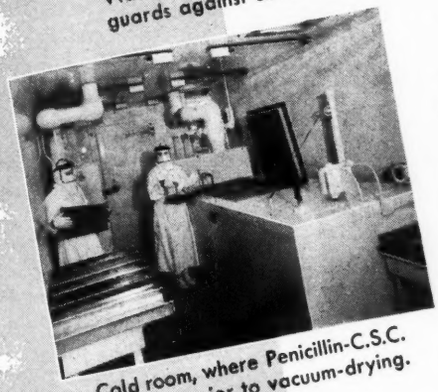
It seems likely that conditions after the close of the war will in some important respects be more favorable than were those in the decade preceding it. In any case the balance of probabilities is strongly on the side of their being far better than those that prevailed on the continent of Europe in the 1920's.

When the advantages of skillful professional investment management are added, it would seem that an effort to preserve the purchasing power of a hospital investment fund would have the odds heavily on the side of a successful result. On the other hand, simply to sit still in the face of such a grave danger and to take no steps to meet it would appear extremely unsound policy.

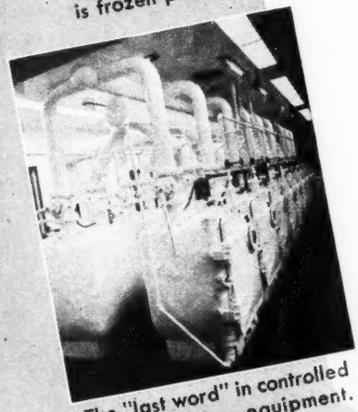
THE "Sterile Area" IN THE PENICILLIN - C. S. C. PLANT



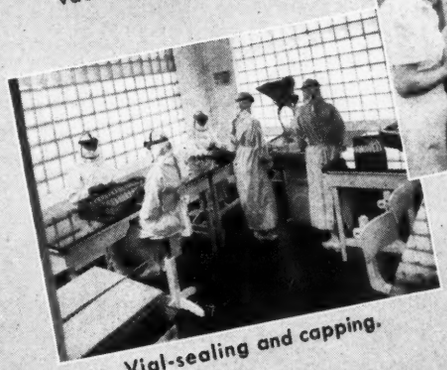
Vial-filling; note the safeguards against contamination.



Cold room, where Penicillin-C.S.C. is frozen prior to vacuum-drying.



The "last word" in controlled vacuum-drying equipment.



Vial-sealing and capping.

WALLS of highly polished opal glass and translucent glass brick, permitting of maximum cleanliness—

rounded wall, floor, and ceiling abutments—

air-conditioning that controls temperature, humidity, and particle content—

sterilizing lamps that destroy air-borne microorganisms—

sterilizing-lamp-controlled "locks" that prevent undue airflow from room to room—

sterile clothing (masks, gowns, shoes, gloves) worn by all technicians—

facial shields which carry the technician's breath away from the work area—

denial of access to all but the technicians assigned to it—

these are but a partial list of the safeguards which make the "sterile area" of the Penicillin-C.S.C. plant an achievement in protection against contamination.

Out of its quarter-century of research and microbiotic manufacturing experience Commercial Solvents Corporation has developed a "submerged culture" method of producing Penicillin-C.S.C. in giant tanks, three stories high, a mode of production as outstanding in economy as the "sterile area" is in safety.

For the physician this combination of mass production methods, skilled personnel, the utmost in safeguards, and unremitting laboratory control spells two assurances—

Penicillin-C.S.C. will always be of dependable potency, sterility, and pyrogen-freedom—

Penicillin-C.S.C., though its entire production is now allocated as the armed forces direct, will be available in adequate distribution throughout the United States as soon as released.

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COMMERCIAL SOLVENTS *Corporation*

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Terre Haute, Ind.

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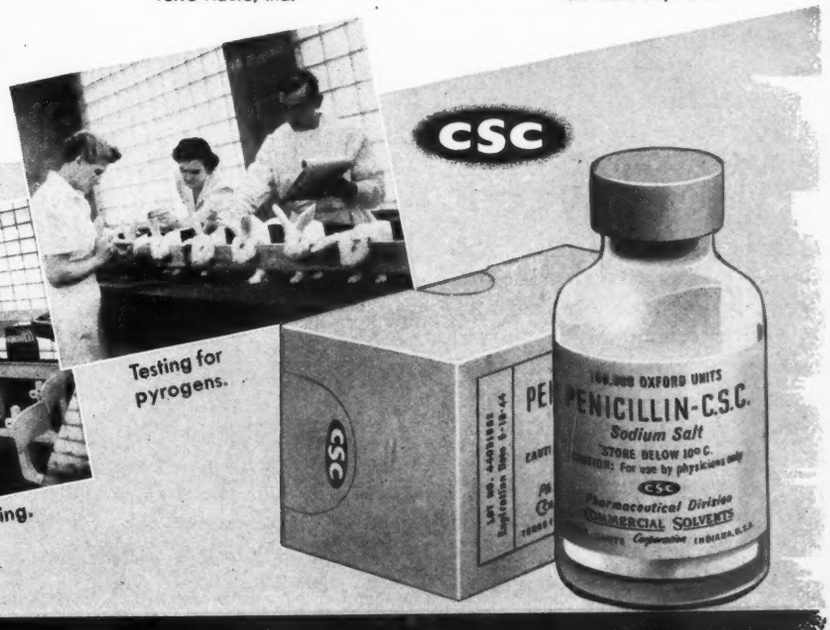


Testing for pyrogens.

—Geriatrics Series—

Behavioral Breakdowns

D. EWEN CAMERON, M.D.

Psychiatrist-in-Chief
Royal Victoria Hospital
Montreal, Que.

THE form and structure of medicine as part of modern society are entering a period of accelerated change. For a time at least they will be exceptionally plastic. What do we know concerning the behavior of the aged that should be directed into this new framework of medicine; what can be used to build preventive and corrective campaigns; what are the most promising growing points for new inquiry?

The behavioral breakdowns in the aged that result in hospitalization are usually end results in a very real sense. Traced backwards, we can often see evidences of stress and of functional failure for many years. In this sense they represent valuable opportunities for us to learn what are the earliest evidences of potentially serious reactions.

CAUSES:

Aging Process. All our later discussion concerning nutrition and environment and such factors as communicable diseases and trauma that tend to precipitate behavioral breakdowns must be considered in the light of the fact that all living things show aging. A few exceptions will be discussed later. To our present knowledge, however, this is a progressive and all but inevitable factor which, whether intercurrent disturbances are added or not, leads to eventual behavioral breakdown. Robertson (1926)[1] showed that the incidence of major behavioral disorders rose, with accelerations, at puberty and the menopause from the earliest years to the last decades when it reached its maximum incidence.

Endocrine and Vitamin Deficiencies. Of recent years it has been asserted with increasing frequency that vitamin deficiencies and endocrine failure are prominent among the causes of behavioral breakdown. The belief that the activity of the sex hormones was positively correlated with the preservation into old age of a sound and vigorous pattern of life is of great antiquity.

In general, it may be said that no good case has been made out for a causal relationship between an active sexual function and a sound pattern of behavior. The reverse may, however, much more readily be asserted, namely, that the sex life of the individual tends to be carried on most satisfactorily and vigorously where sound mental and physical health is preserved and that it may be anticipated that, when the 70 year old man is active, alert and capable of giving a good account of himself in work and social relations, it is likely that his sex activity may be maintained at a higher level than is the case where it is clear that he is already breaking down into infirmity.

The situation with reference to the activity of the thyroid is rather more obscure. It has long been known that oxygen consumption diminishes substantially with advancing age. In a series of men and women of varying ages Kise and Ochi (1934)[2] found that in the sixth decade 36.05 and 34.02 calories per square meter per hour were consumed by the average man and the average woman, respectively. During the ninth decade the respective volumes were 32.06 and 30.042. The question at once arises as to whether this represents a true thyroid deficiency or whether there is a progressive failure in the supply of oxygen apart from a deficiency of thyroid.

There is a great deal of information that indicates that the supply of oxygen in the aged person is reduced —the tidal exchanges in the lungs are reduced, the transfer of oxygen through the lung alveoli is lessened by emphysema and by fibrosis of the capillaries. A moderate degree of secondary anemia is commonly found in the aged and the circulation time is reduced. Cameron et al. (1940)[3] found the arm to carotid circulation time to be twenty-five seconds in the aged, in place of the normal eighteen seconds.

From studies of the oxygen output of the blood before and after it has passed through the brain of senile individuals, it was suggested that there was reason to suspect that less oxygen was being utilized by that organ than is the case in younger persons.

Actual use of thyroid in aged persons has, however, failed to provide consistently favorable results. It is true that in occasional instances improvement appears, the patient finds himself more active and vigorous, grasp is keener and the memory may become somewhat more reliable. On the other hand, it is at least as often found that the increased metabolic rate imposes too great a load on the individual who loses weight, becomes tremulous and may show evidence of cardiovascular strain.

Comparatively little is known about the use of the other endocrines in the aged. It may be mentioned that it is customary to find some evidence of insulin deficiency in the later years but this is usually in a measure that is quite unlikely seriously to disturb behavior.

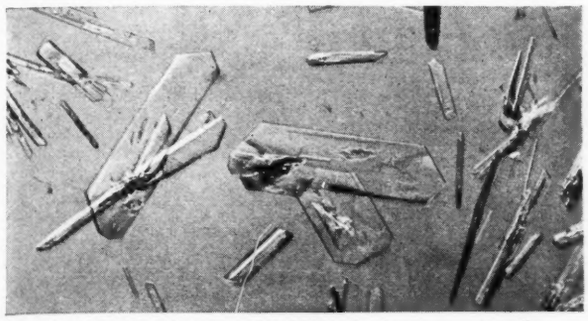
Considerable attention has been directed to the vitamins in the later years. It has been pointed out that

[1] Robertson, G. M., Seventh Maudsley Lecture, The Prevention of Insanity—A Preliminary Survey of the Problem, J. Ment. Sci. **14:** 454-491 (1926).

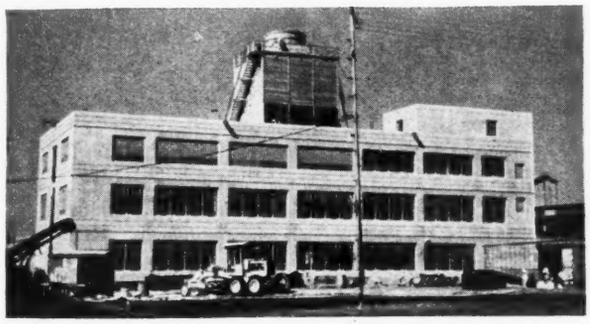
[2] Kise, Y., and Ochi, T., Basal Metabolism of Old People, J. of Lab. & Clin. Med. **19:** 1073-1079 (1934).

[3] Cameron, D. E., Himwich, H. E., Rosen, S. R., and Fazekas, J., Oxygen Consumption in the Psychoses of the Senium, Am. J. of Psychiatry **97:** 566-572 (1940).

Mycelia and spores of *Penicillium notatum*. Growing in a liquid culture medium, this mold produces penicillin which later is extracted and purified.



Crystals Penicillin Sodium Squibb X100. In the course of studies concerned with the chemical structure of penicillin Dr. H. B. MacPhillamy and Dr. Oskar Wintersteiner were first, July 1943, to accomplish crystallization of penicillin sodium; activity about 1,600 Oxford units per milligram.



New Squibb Penicillin Building, now in operation. Built without government subsidy, it is designed and equipped for the most efficient production and control of penicillin. Instead of a few pounds, now over a ton of mold is grown each day. Its productive capacity is not exceeded by any other penicillin plant in the United States.

Unusual care maintains purity, activity and stability. Workers package Penicillin Squibb in air-conditioned rooms sterilized with ultra violet light. For over two years Squibb has produced penicillin for the National Research Council and the Armed Forces.

SQUIBB HAD *Penicillin* READY

WHEN the War Production Board's Office of Civilian Penicillin Distribution recently announced the limited allocation of penicillin for civilian use and the plan for its distribution, the Squibb Laboratories were ready with a substantial supply after having first met the requirements of the Armed Forces, Lend Lease and the Office of Scientific Research and Development.

The Squibb Laboratories have been actively engaged in the development and production of penicillin ever since the first culture was received from England in the autumn of 1940. Remarkable changes have occurred in the method of manufacture. Huge tanks have replaced bottles for growing the mold; production time is less than three days instead of two weeks.

It is hoped that the day is not too distant when penicillin production in the United States will be sufficient to eliminate the need for allocation. We want physicians to know that Squibb is doing everything possible to hasten the coming of that day.

SQUIBB

A Name You Can Trust

vitamin C in both blood and spinal fluid is low (Plaut and Bülow, 1934)[4] and Remp et al. (1940)[5] found that it was difficult to raise these levels on dosages that were adequate for younger persons. This suggested that assimilation was defective. When these levels were raised, however, no appreciable change in behavior was noted.

The various constituents of the vitamin B complex have naturally been closely investigated and in recent years nicotinic acid was reported as being quite dramatic in its action in senile states accompanied by confusion and stupor. This early report has not been well supported by subsequent workers.

Intercurrent Disorders. A breakdown anywhere in the economy of the aged individual may be sufficient to cause disturbances of behavior. We now understand that the maintenance of behavior within normal limits depends upon, among other things, the maintenance at normal levels of certain fundamental functions. Among these are oxidation, hydration and the elimination of metabolic breakdown products.

In the aged individual the range within which these functions may vary appears to be narrower than in the younger person. Consequently, one finds that cardiac decompensation, with its attendant interference with oxygen transportation, is particularly likely to be associated with the appearance of excitements and confusional states in the older person. The same is true of disturbances of the renal function and of those conditions that result in dehydration.

Less well understood are the effects of those disturbances in function that interfere with the usual routine of the individual and which, while reasonably well tolerated in the younger person, are particularly likely to cause behavioral breakdowns in the aged. Prominent among these are leg fractures, which cause the individual to be immobilized in bed, and temporary loss of vision, as after operation for cataract. These reactions might appropriately be termed "pattern fracture" breakdowns since they appear to result essentially from the frustration attendant upon the breakdown of a daily routine to which the individual has become adapted over a long period of time.

Social and Psychological Factors. These appear to constitute, apart from the aging process, by far the most important causes of behavioral breakdowns in the aged.

In order to explain them it is necessary to grasp the fact that our industrial civilization has pressed particularly heavily upon older persons. We can be easily misled by the prevalence of discussion and action concerning old age pensions and other forms of assistance. Actually, these are reactions, and inadequate ones at that, to a serious situation.

In our society the individual, as he passes into the older age groups, finds himself progressively dislocated from both work and family groups. Employment is difficult for him and, with the disappearance of the rural type of family, he finds that the members of his family group tend to scatter into industrial employment in distant areas.

When his wife dies he frequently finds that there is little left for him except subsistence in a boarding room area. It is at this point that we find many behavioral breakdowns occurring. Insecurity, anxiety, loneliness and frustration are the four great agents of these breakdowns.

TYPES OF BREAKDOWN:

Practically all the kinds of behavioral breakdown that are known to occur in human beings may appear in the later decades and may, moreover, appear for the first time. Hysterias and anxiety states, manic reactions, disturbances resulting from brain syphilis or alcoholism have all been reported as appearing in the aged. In the majority of instances, however, they appear against a background of behavioral change that arises from the progression of the aging process. Frequently, this change is the most important or is the only one present.

Briefly, the aging process may be stated as showing itself in a progressive difficulty in adaptation, in growing inability to remember day to day events, in slowness of grasp and in emotional instability. As these changes progress, adaptive difficulties and emotional instability conspire to produce the same serious depressive reactions. The memory disturbances pass on to disorientation and internal confusion, inability to grasp what is occurring leads to progressive misinterpretation and we eventually obtain a series of related disturbances of behavior in which disorientation, confusion, delusions of persecution and hallucinations are prominent.

MANAGEMENT:

The management of these later decades must, in the first instance, be preventive. Once the profound disturbances referred to are established, our control over the situation is quite limited. Therefore, every effort has to be directed toward early recognition of possible disturbing factors.

The most important of these factors fall into three main groups: those arising from the aging process itself; those constituted by intercurrent disorders, and those that may be designated as social. Insofar as so little is known concerning the aging process, this matter will be discussed later under the topic of the management of research.

Certain of the social factors in behavioral breakdowns in the aged are now sufficiently well defined to permit our proceeding to develop a preventive campaign based upon our knowledge of them. The primary step must be to prevent the person of advanced years from being dislocated from his social groups. One of the few fortunate consequences of this war has been that it has tended to keep in employment considerable numbers of men and women who, in times of plentitude of labor, would have lost their jobs to younger persons. That time will probably come again.

In the interval, research has indicated that older persons have definite assets in the industrial field. Prominent among these is their great reliability. Second, it is now known that the capacity to learn new skills is maintained much longer than was at one time thought to be the case and, finally, while their speed of working is reduced, at least in more advanced years, their experience constitutes a real asset. With the growth of job analysis, it is becoming increasingly possible to place older persons in positions in industry in which they can make a real contribution.

In order to maintain their integra-

[4] Plaut, Bülow, M., Ueber den Einfluss der Nährung auf den C-vitamingehalt des Liquor cere Brospinselia, Ztachr.f.d. ges. Neurol.u. Psychiat. **152:** 324-336 (1934).

[5] Remp, D. G., Rosen, S. R., Ziegler, G. B., Cameron, D. E., Ascorbic Acid Levels in Patients Suffering From Psychoses of the Senium, J. Ment. Sci. **86:** 534-537 (1940).

tion in groups outside work it is probable that some new types of social organization may have to be introduced. There seems little probability that the trend to family dispersal that has been dominant for the last half century will show reversal in the near future. Under these circumstances it will be necessary to consider the possibility of setting up special social groups.

Just prior to the outbreak of the war we attempted, in Albany, N. Y., to deal with the local situation by developing Leisure Time Clubs. This local situation arose from the presence of large numbers of aged individuals living in the low-rental rooming house areas of the city, many of them alone. Some, especially those who had a degree of infirmity that prevented their getting up and down stairs, saw no one for days on end.

Among this group there developed a high behavioral breakdown rate; depressions, suicidal attempts and confusional states were common and led to the necessity for hospitalizing these old people in considerable numbers in the psychiatric department of Albany Hospital. Our purpose in setting up the Leisure Time Clubs was primarily preventive. They were to provide centers for the development of social relations among these people.

Many of these older persons had a considerable residuum of skill. This was utilized as a means of bringing them together in groups to carry on tag and ornament work. The outbreak of war, unfortunately, prevented full development of the plan but the spread of the Townsend Clubs suggests the extent to which the need of social interaction is felt by these older persons. Clearly, it will be necessary for us to work toward the idea of cities planned in respect to their social as well as to their material structure and to foster the development of personnel who may be thought of as social architects.

Preventive work can also be related to intercurrent disorders. The fundamental principle to be kept in mind is that any disorder that interrupts the usual pattern of living of the older person constitutes a psychological danger that is much greater for him than it is for the younger person. Consequently, it is most desirable to avoid confining the aged person to bed unless it is absolutely necessary. It is equally desirable to avoid immobilizing him by the application of splints or casts.

The question of whether to carry out an operation for cataract often presents a most difficult problem. A considerable number of confusional states appear in older persons who, following such operations, have had to wear eye shades for a period.

At this point the undesirability of using long-acting sedatives may be stressed. Bromides and most members of the barbiturate series are to be avoided. Their use is frequently followed by confusional states in which visual hallucinations may be present. Such patients, however, usually react reasonably well to chloral hydrate and to peraldehyde.

RESEARCH:

Men come to the study of aging by many roads. They come to study aging as it affects the capacity of the industrial worker. They are now studying it with growing concern in its relations to social structure.

Information concerning the aging of special tissues and of many different kinds of organisms has been accumulated over the past several decades. The stage is now being set for a great forward surge of work in this field.

Standing on this difficult ground over which we have slowly made our way, we can look down into the wider fields in which we shall work in the next few years and observe something of the tasks and of the tools that we may, at least at first, have at our disposal.

First, as to the expectations of those setting out to work on aging. To know this is of some importance for their expectations—their general premises, their points of view, their concepts of the problem as a whole—will eventually determine in large measure the nature of the work they undertake and, indeed, in some measure the conclusions they will draw.

Let us say at once that there is no unanimity of point of view. In tackling such an extensive field this is, of course, a great advantage. Until we have evolved a reliable scheme for the investigation of new fields it is much better that we should send out many different expeditions heading in different directions.

Among the points of view the first, and probably oldest, is that the process of aging is inevitably tied up with that of living, that it is an innate characteristic of human organism. Those who entertain this concept hold to the naturally derived belief that while we may reasonably study aging as a matter for scientific inquiry, we should not anticipate that we shall be able to control it.

Then there are those who hold a somewhat similar but modified concept. They maintain that aging is inevitable but that the vicissitudes of life tend to limit what they term the natural span. They believe that by ensuring the optimum diet, by reducing to a minimum the amount of toxic action to which he is exposed during this life, by protecting him as far as possible from the wear and tear of psychiatric traumata, the length of life of the average man can be greatly increased. He should remain relatively vigorous, free from the depressing and crippling infirmities of life until, all aspects of his organism having reached their natural limits, the end would come rapidly.

Finally, there are those who, in recent years, have begun to insist that aging, while admittedly widely found in living things, is nonetheless a disorder of life, not an inevitable accompaniment.

This is, of course, the most stimulating approach to the problem of aging. It is, moreover, now supported by more than mankind's most natural hopes. Research, over the past several decades, has shown that among the simplest organisms there are some that do not show aging. Their lives are terminated, if that is the correct term, by a process of fission, which may be repeated many hundreds of times before any evidence of senescence appears.

With the growth of the tissue culture work, we know that it is apparently possible to keep a piece of tissue alive indefinitely. Finally, we have an exceedingly interesting feeding experiment in rats, in which, by limiting the diet in the early years, it has been possible to extend the life of the animal far beyond its natural span.

Inquiries such as these have given great impetus to the study of aging and the knowledge which their further pursuit will furnish most certainly will provide us with increased means for the control of disturbances in living in the later decades.

Antispasmodic Drug Action

A. M. LANDS

Department of Pharmacology, Wayne University, Detroit

THE development of effective agents in the treatment of painful contractures of visceral organs has been brought about largely through the cooperative efforts of a large and heterogenous group of scientists. Indeed, this project may well serve as an example of the manner in which the varied talents of the chemists, experimental pharmacologists, clinicians and manufacturing pharmacists can be united in an effort to solve a specific problem.

In the following paragraphs I shall outline briefly some of the more salient points in the development of our present knowledge of antispasmodic agents and indicate the present lines of research.

Physiology: Organs composed largely of smooth muscle tissue are capable of involuntary, automatic activity. The regulatory control exerted by way of the autonomic nervous system is superimposed upon this substratum of activity in such manner that it may be increased or decreased in accordance with the needs and activities of the organism as a whole.

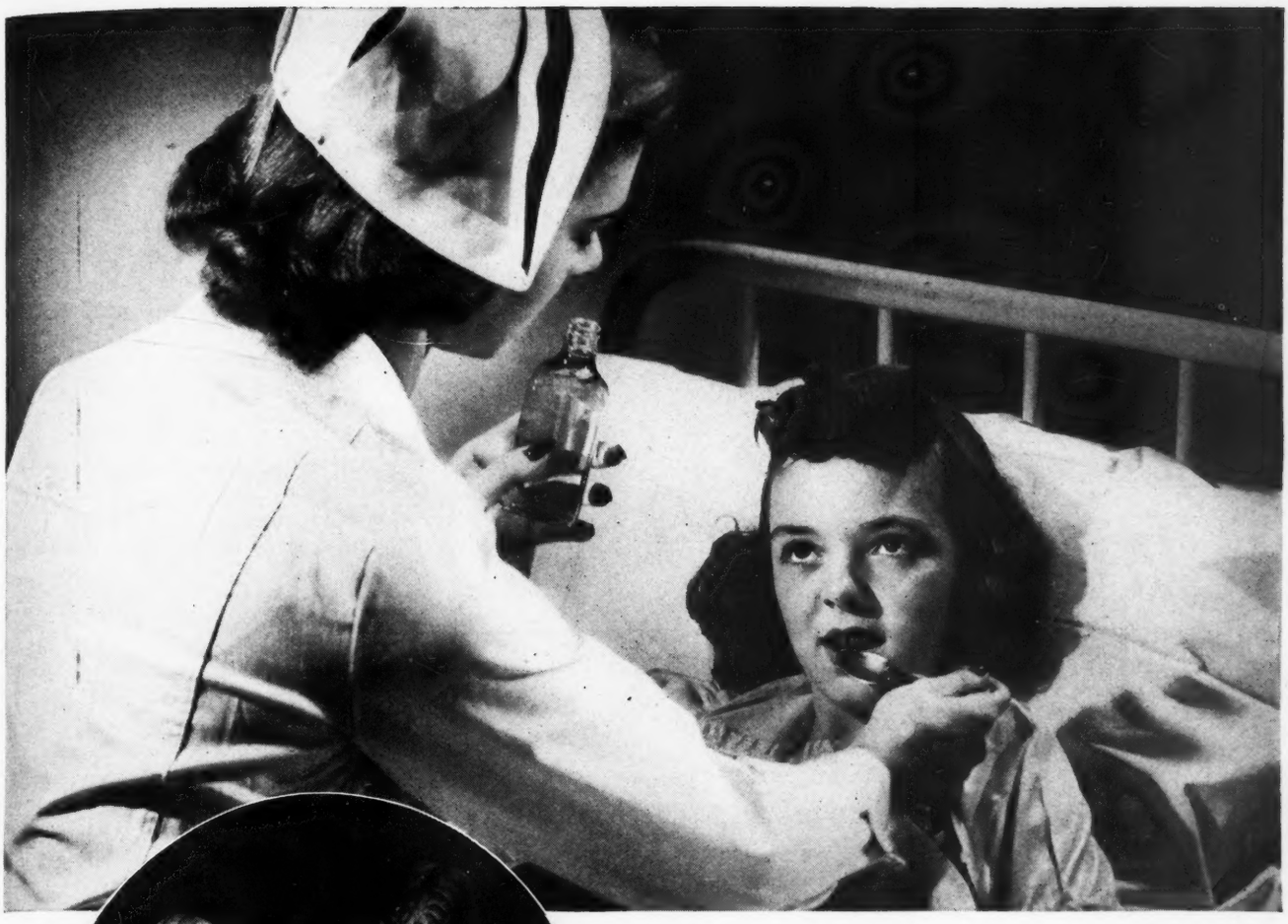
Thus, in fear or anger, activity of the gastrointestinal tract is diminished simultaneously with the increased activity of the skeletal muscle organs. This inhibition of visceral activity is brought about largely by discharges over the sympathetic division of the autonomic nervous system, augmented by the aid of the sympathomimetic hormone, epinephrine.

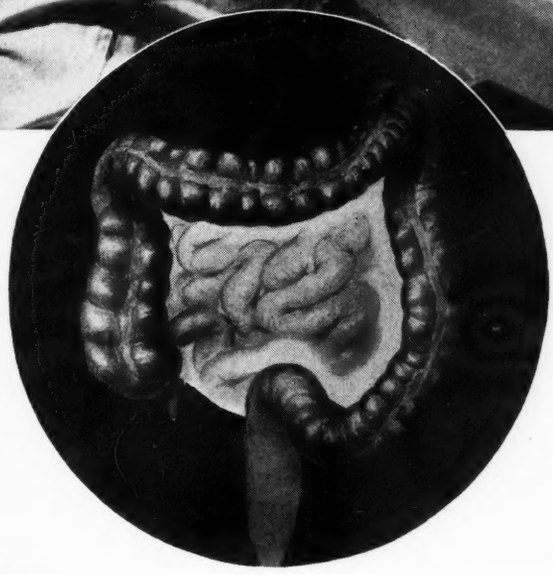
Conversely, in quiet states, the predominant activity is that of the parasympathetic division of the autonomic nervous system. As an example, we may take the gastro-colic reflex initiated by the ingestion of food. This results in increased colonic activity and induces a desire to defecate, thus evacuating the large bowel in advance of an increment of new material.

From time to time, activity patterns characterizing normal digestion become deranged. These abnormal patterns may often involve hypermotility and spasticity. Of particular concern are the painful spasticities of the colon of obscure origin and ureteral colic brought about by mechanical irritation. Primarily, these are examples of "hypermotility."

The classical investigations of Dale, Barger, Cannon and others have elucidated the manner in which the autonomic nerves bring about a moderating influence upon this "self activity" characteristic of visceral organs. They have postulated the liberation of specific chemical agents in response to nerve impulses arriving over the autonomic nerve fibers. Thus, the parasympathetic (cholinergic) division causes the liberation of the specific agent, acetylcholine and the sympathetic division, the sympathins or "epinephrine-like" substances. Acetylcholine increases whereas epinephrine and the sympathins usually decrease visceral tone.

Antispasmodic Activitv: In cases of hypermotility and spasticity of the gastrointestinal tract, it is conceivable that reduced activity could be brought about by (1) agents whose presence directly depresses the activity of the visceral muscle cell or (2) agents that neutralize or replace acetylcholine. Actually, both types of agents have been discovered. They were first obtained from natural sources and at a relatively early time were put into practice.





FOR CONSTIPATION DUE TO MEDICATION...

You know only too well that a number of useful, necessary medications may induce constipation as an unfortunate by-product. The normal cycle of bowel evacuations is thrown off schedule.

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Antispasmodic Drug Potency

Drug	Maximum Effective Dilution*	
	Acetylcholine Spasm	*Barium Chloride Spasm*
Papaverine	0.1– 0.2	0.1 –0.2
Sestron	0.5– 1.0	0.5 –1.0
Cyverine	0.5– 1.0	0.5 –1.0
Eupaverine	0.2– 0.5	0.2 –0.5
Syntropan	0.5– 1.0	0.1 –(?)
Trasentin	0.5– 1.0	0.1 –0.2
Trasentin-H	2.0– 3.0	0.2 –0.5
Pavatrine	2.0– 3.0	0.1 –0.2
Atropine	25.0–50.0	0.005–0.010

*Potency was determined on the isolated rabbit jejunum according to the method of Magnus. All values are expressed as multiples of a million.

Papaverine, an alkaloid found in opium to the extent of about 1 per cent, was isolated in 1848 and introduced into medical practice in 1913, following the investigations of Pal. Atropine was isolated by Mein from belladonna in 1831. Knowledge of the use of the belladonna alkaloids in the form of the crude drug antedates its isolation by many years.

Extensive pharmacological investigation has demonstrated that papaverine acts principally by directly depressing the activity of the visceral muscle cell. It is customary to evaluate antispasmodic activity in terms of the relative concentrations that will relax spasm of the isolated rabbit or guinea pig jejunum suspended in a suitable isotonic solution.

Spasm comparable to that induced through nervous stimulation can be produced by acetylcholine or pilocarpine. Spasm resulting from direct (musculotropic) action can be simulated by treatment with barium chloride or histamine. The accompanying table gives a summary of the antispasmodic activity, for some of the commonly used antispasmodic drugs, obtained in this manner.

Various modifications of papaverine have been devised. Eupaverine, containing a methyl group in the 3 position and with two mythelene oxide groups, is probably one of the most interesting modifications of this structure. In order to avoid certain defects inherent in the isoquinoline nucleus, new compounds were synthesized in which the basic pattern is that of a relatively simple amine.

Two of the more important ones are sestron, ethyl di-(gamma-phenylpropyl)-amine HCl, and cyverine, methyl di-(beta-cyclohexylethyl)-amine HCl. It will be noted from the table that these compounds, like papaverine, act as direct depressants of the visceral muscle cell. None possesses activity comparable to that of atropine.

Agents capable of significantly diminishing or abolishing the stimulating action of impulses arising in the parasympathetic division of the autonomic nervous system belong chemically to the ester type. Atropine is the ester of the complex amino alcohol, tropine and tropic acid. This substance is extremely effective in blocking the action of parasympathetic (cholinergic) nerve impulses.

However, therein also lies its principal disadvantage. Doses effective in relieving visceral tension often cause dryness of the mouth, increased heart rate, mydriasis and other disturbances associated with generalized paralysis of cholinergic nerve transmission. This has prompted extensive research in an effort to devise compounds whose use

will produce effects limited to the visceral musculature, that is, would abolish hypermotility and tonus of these structures without simultaneously inducing alterations in other cholinergically innervated organs.

The mandelic acid ester of tropine, known under the trade name of homatropine, was among the first of these new synthetics to be introduced. At the present time, its use is principally limited to ophthalmology in that it causes transient mydriasis and may be used in children to induce cycloplegia of short duration.

The methyl bromide of homatropine, novatropine, is a mild antispasmodic frequently used in gastrointestinal disorders. Eumydrine (atropine-N-methyl nitrate) is qualitatively the same as atropine in its actions but is significantly less potent and less prolonged. None of these substances has any important papaverine-like activity.

Eucatropine is the mandelic acid ester of a complex amino alcohol. This substance is a weak anticholinergic drug and is used to induce mydriasis of short duration. It does not paralyze accommodation.

The fact that eucatropine contains neither tropine nor tropic acid and still possesses some anticholinergic activity suggested the possibility that simpler substances could be devised that would have useful antispasmodic activity. A large number of such esters have been synthesized and tested pharmacologically. Syntropan, the ester of the tertiary amino alcohol 3-diethylamino-2,2-dimethylpropanol and tropic acid, is an effective antispasmodic agent but as with the previously mentioned esters, it is only weakly active on musculotropic spasm.

Trasentin, the diphenyl acetate of 2-diethylaminoethanol, is probably one of the most widely used antispasmodics. This substance is orally effective and causes practically none of the undesirable side actions of atropine, in the doses usually administered.

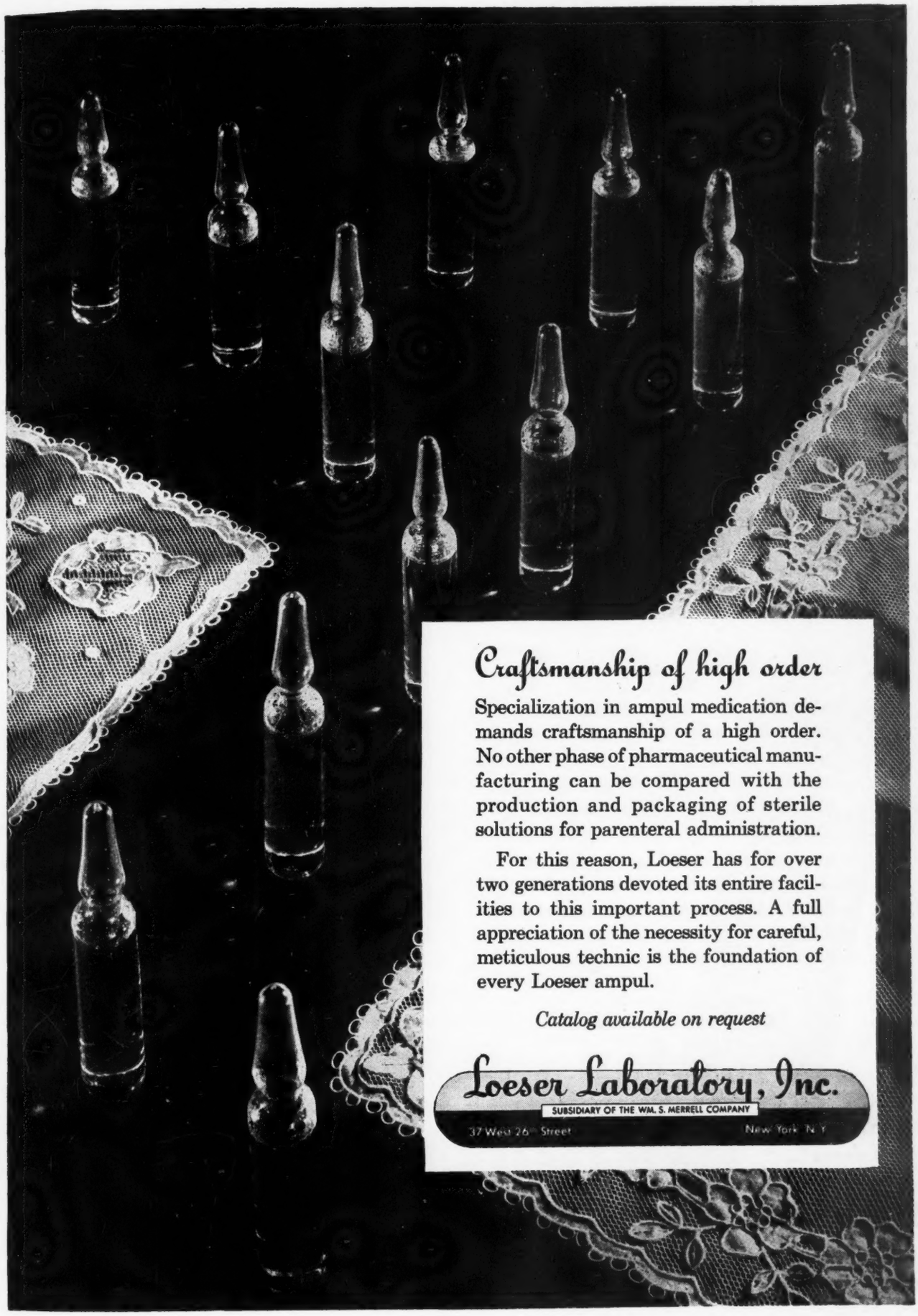
More recently, there have appeared reports describing the experimental use of a new trasentin analog, trasentin-H, in which one of the benzene rings of trasentin has been replaced by the saturated cyclohexyl ring. This substance is reported to be somewhat more active than trasentin without the change in structure causing any great increase in toxicity.

Most recently, there has been introduced a new antispasmodic under the trade name of pavatrine in which the two benzene rings of trasentin are joined by a carbon-to-carbon bridge to give the 2-diethylaminoethanol ester of fluorene-9-carboxylic acid. This substance is reported to be more active than trasentin and to be approximately equal to trasentin-H in its antispasmodic activity. Like trasentin, it is almost free of the undesirable actions of atropine.

Conclusions: Many synthetic compounds have been prepared and tested for their antispasmodic activity. An ideal substance (1) should be effective when taken orally, (2) should exert its action principally on the visceral muscles, (3) should not alter the intrinsic motility pattern of these organs and (4) should have low toxicity.

The most effective synthetic agents now available exert their action largely on abnormal motility patterns induced through the autonomic nervous system. Many clinicians have suggested the importance of psychogenic factors in the etiology of spasm and hypermotility of the gastrointestinal tract. Antispasmodics of the ester type would be most useful here and, in fact, trasentin and pavatrine have been used with good result.

Agents equally effective in relaxing the spasms of musculotropic origin are yet to be synthesized. Research is continuing in many laboratories and it is probable that the postwar decades will see the introduction of many new and useful synthetic antispasmodics.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CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Venipuncture Technic

Dr. R. Charles Adams in the April issue of *Surgery, Gynecology and Obstetrics* discusses the means of improving the technic of venipuncture. As performed by medical students and interns, this technic is notoriously poor in many cases, despite the large number of venoclyses performed daily. These are now performed routinely for the administration of fluids, whole blood, plasma or other blood substitute, for the introduction of medicaments, such as the sulfonamides, penicillin or arsenical drugs, for obtaining blood for study, for the injection of dyes for diagnosis, for the introduction of sedatives and for the administration of anesthetics.

In the majority of instances, venipuncture may be accomplished without difficulty whether the technic is good or bad. But in the remaining minority good technic is absolutely necessary and it is in these cases in which the worst evidences of poor technic occur: multiple punctures and hematomas.

The first step toward the institution of efficient venipuncture is the standardization of equipment, and the next, the training of interns and residents in the use of this equipment. The institution of such standardization will save both time and money and will decrease delay at the bedside when delay may sometimes be disastrous.—SIGMUND L. FRIEDMAN, M.D.

Sulfamerazine Treatment

Anderson, Oliver and Keefer reported the results of the sulfamerazine treatment of 278 patients suffering from various types of bacterial infections in the *New England Journal of Medicine* for March 30, 1944.

The authors approached their evaluation of these results and of the drug as a chemotherapeutic agent by comparing their results with those obtained by the use of sulfadiazine in the treatment of those diseases in which sulfa therapy has been well standardized, namely, pneumococcal pneumonia, meningococcal meningitis and erysipelas.

In pneumococcal pneumonia, sulfamerazine showed an effectiveness similar to that of sulfadiazine, but the total dosage necessary for adequate treatment was about one half to one third less than the amount of sulfadiazine ordinarily used.

Fifty consecutive cases of meningococcal meningitis were treated without a single death. Sulfamerazine thus proved itself to be a potent and efficient drug in the treatment of this disease, equal to if not surpassing sulfadiazine.

In the treatment of erysipelas, sulfamerazine was found to equal sulfadiazine in efficiency. And, again, the average total dose of the former was about half that of the latter.

Toxic reactions to the sulfa drugs have always been of importance and it was found that, with sulfamerazine, the incidence of nausea and vomiting was somewhat higher than that ordinarily encountered after the use of sulfadiazine. The number of toxic psychoses approached the average incidence of this reaction in sulfadiazine-treated patients. Sulfamerazine, however, appeared to have a greater tendency to produce leukopenia.—SIGMUND L. FRIEDMAN, M.D.

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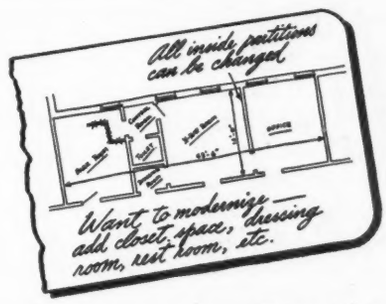

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Westinghouse X-ray Engineers will follow your plans—and submit a carefully worked-out plan for handling patients and radiographic routine with the greatest efficiency.

FOOD SERVICE

The Outlook for 1944 on the *FOOD FRONT*

R. C. SHERWOOD
Assistant to the Chief
Civilian Food Requirements Branch, W.F.A.

GAINS have been made on most food fronts during the present year. In terms of nutrients, the estimated food supply available for civilians is equal to or better than 1943. Shortages that have occurred have been inconveniences rather than hardships.

Per capita consumption of meat for the first part of 1944 will be 18 pounds higher than last year. The average for the year will probably be eight pounds more. There will probably not be abundant meat supplies in the last half of the year.

Prospect for Dairy Products

Egg supplies will probably be slightly less and this also applies to chicken. Fluid milk will be at about the same level with slightly less evaporated milk for civilians. At least as much dry-skimmed milk for food industries will be available. Butter supplies will be slightly larger. Margarine will be ample, with an increase over last year for civilian consumption. Current stocks of edible fats and oils are good.

Grain supplies are more than sufficient for food needs, but there are extra demands for these for alcohol manufacture. While corn supplies are ample, the problem of relationship between price and distribution has not been solved either for civilian consumption or for manufactured products.

While oats and rye are adequate, there may be difficulty in obtaining the quality needed for breakfast cereals. Civilian rice supplies may continue short of the demand.

The fresh vegetable situation is good, but victory gardens and home canning are most important, as the requirements of our armed forces are increasing. Citrus fruits are more plentiful this year, and there are good prospects for other fruit crops. Canned fruits will continue short of demand, but there will be at least one third more raisins and one fourth more prunes. Sugar allotments will be about equal to those of last year.

Niacin Situation Unsatisfactory

Synthetic thiamin and riboflavin are available for cereal enrichment, but the niacin situation is far from satisfactory. Synthetic ascorbic acid (vitamin C) is being allocated for various uses. There is enough vitamin A for the small amount used in fortification of food, especially margarine.

In our work as a claimant of food for civilians we use the recommended daily allowances of essential nutritive factors estimated by the Food and Nutrition Board of the National Research Council, although we recognize that a satisfactory average diet does not mean that all persons are eating well.

In calculating the average content of nutrients, rough allowances are made for cooking losses, but none is made for the loss in discarded edible portions. The figures show that there are a large enough calorie allowance and improvement in protein, calcium and vitamin A supplies over the 1935-39 average, a large increase in vitamin C and a marked increase in iron, thiamin, riboflavin and niacin.

The enrichment of bread, cereals and flour has had a most significant effect upon the diet of this country. About 65 per cent of all white flour is enriched by millers or bakers. All commercial bakers must enrich white bread and rolls but there is no federal requirement to enrich products made in hotels, restaurants and other institutions.

There has been no federal order to enrich family flour but six states require this. Many cereal breakfast foods are also enriched.

Office Serves Four Purposes

As a claimant for civilians, our office has four functions:

1. Determining of the food requirement and the size of the prospective supply.
2. Stimulating production and processing when shortages are imminent.
3. Aiding equitable distribution.
4. Looking after special needs of industrial war workers and other special groups, such as infants and children.

Farm food production has increased one third over the 1935-39 average and could be further increased considerably. This would permit foreign relief feeding of large numbers without disturbing a good diet for our own population.

Estimates of current food supplies show that we can be a fairly well-fed nation with only minor changes in eating habits, none of which need impair nutrition. The ideal objective will not be obtained until nutritious foods are so equitably distributed that each individual gets his fair share of nutrients in the nation's food supply.

Presented at the meeting of the New York State Dietetic Association, June 1944.

Cereals Simplify Things

E. ALLIENE MOSSO
Supervising Dietitian, St. Luke's Hospital, New York City

THE fine weather and long week ends which are so much enjoyed nowadays bring headaches to those interested in serving food. This is particularly true in hospitals where it is impossible to close the doors when the cook, bus boy or butcher decides to stay out. People who are ill must be fed at least three times a day no matter what the cost.

In prewar days, a shortage of even two or three employes was sufficient to justify an SOS for emergency aid. We were not oriented to changing our ideas and felt we must follow a set pattern of work. Since then our ideas have changed and are continuing to change, and for the duration it is up to the ingenuity of the dietitian to anticipate help shortages and to plan meals that call for a minimum amount of preparation without sacrifice of appetite appeal and nutritive value.

Cold Cuts Become Monotonous

There is no need to keep using the oft-repeated cold cuts and potato salad for holidays and Sunday nights with monotonous regularity. We should put on our thinking caps and plan other nourishing dishes that score equally high as labor-saving devices.

While it is true that the combinations of cold cuts and potato salad are appetizing and well liked by most people, they, like egg salad, chicken salad, sandwiches and hot foods, require considerable preparation and the time of employes. On the other hand, cereal, which went out of favor with many of the so-called reducing diets, requires almost no preparation and gives excellent food value.

Cereals have been such a basic part of hospital menus and it was so easy to take them for granted that we have overlooked many opportunities for using them on luncheon and supper menus as a hot-weather specialty.

At St. Luke's Hospital in New York it is our custom to keep supplies of cold cereal on the cafeteria counter that serves doctors and nurses. It has been a surprise to see how many times a cold cereal is chosen in place of the regular meals. This is particularly true during hot weather when the nurses and doctors come to the dining room tired and warm.

We offer cereal on the supper menu at all times and have found that many people prefer it to the regular meal. It is light yet sustaining and is mild in flavor.

Last summer some of the New York hospitals tried an interesting experiment on the potential popularity of cereal entrées. There were varying results from the participants, depending to a large extent on the method of presentation. In some places where the dishes were made particularly attractive, the cereal luncheon was well received. In one hospital a corn flakes-fresh peach-and-cheese combination was served on the same menu with smothered chicken, assorted cold cuts and fillet of sole. Out of 100 patients, 36 ordered the cereal-fruit-and-cheese combination.

There is, of course, no need for providing such popular alternatives when one is trying to save labor. The test is merely quoted to show that the cereal dish can be popular in hot weather and will therefore help to alleviate the employment situation.

Furthermore, in promoting cereals, dietitians are tying in with the government's program which seeks an increase of 25 per cent in cereal consumption in addition to easing its own labor shortage problems. In view of the uncertainties of fruit supplies, it is fortunate that cereals combine happily with just about every fruit or berry that may be available. So when planning a cereal combination as a supper or luncheon entrée, one can confidently choose whatever fruit is abundant to serve with it.

Stewed prunes or raisins, stewed or baked apples and fruited gelatins are staples that hospital kitchens usually have on hand and they are all delicious in combination with any ready-to-eat cereal. If protein is needed in the menus, cottage cheese is unrationed and popular with most hospital patients. Fortunately, too, it's an easy matter from a labor standpoint to add a tablespoonful of cottage cheese to any cereal-and-fruit combination. It also makes an attractive addition to the meal.

Cream cheese, although sometimes rationed, is relatively abundant and offers another variation that is popular as well as nutritious.

Offer Patients a Choice

Bananas are now more plentiful and combine well with every type of ready-to-eat cereal. Quick-frozen peaches and blueberries served with cereal can be counted on as special treats that even a discriminating patient is likely to applaud. A mixed compote of figs, prunes and raisins also combines deliciously with any prepared cereal. When a cereal dish is featured as a luncheon or supper entrée, it is good strategy to offer patients a choice of the cereal they prefer.

This adaptability of cereals to a wide variety of combinations is an important factor in their use as a labor-saving device. As a war-time measure, dietitians will want to explore the possibilities of these combinations, which will reduce the food budget, give satisfaction to the patient and relieve the employment situation within their institutions.

This Business of Rationing

(Continued From Page 73)

As to the success of their efforts at collecting ration books from patients who did not bring them when they came, hospital administrators report variously: "very good," "fair," "little success." Apparently much depends on the salesmanship of the point collector and on the memory and willingness to cooperate of the patient's family.

When the questionnaire was mailed, butter had a high point value and many larger hospitals were giving patients very small servings and serving it to employes once a day only. In some hospitals and states where the serving of colored margarine is prevented by state and federal law employes were being served the wholesome but lardlike uncolored variety, along with gravy, jam, jelly, peanut butter and the like.

Butter Is Still Served

However, 85 per cent of our small hospitals report that patients were and are getting butter and, surprisingly enough, when the patients get it the employes get it, too. The other hospitals serve margarine occasionally and many of them use it in cooking, of course.

A sanatorium up in the dairy state of Wisconsin found it necessary when the point value of butter was high to reduce the size of its pats of butter served patients. The machine that sliced the butter could not be adjusted to cut thinner slices and, of course, it was impossible to buy a new slicer so the pats were cut in two horizontally.

The uproar that went up in every room, ward and porch was terrific. Some patients threatened to go home and most of them wrote letters to relatives and friends about their plight until the postman began arriving with mail dripping with grease as the patients' correspondents started sending in butter even in ordinary envelopes. Little jars of butter marked with each patient's name had to be kept in the sanatorium's refrigerators and brought out three times daily by the already overworked dietary staff and put on the proper trays. Often his private butter supply disappeared sooner than the patient thought it should—for everyone was suddenly more interested in butter than any other item of diet—and he would raise a protest that some of his butter was being given to others. What a headache it all was!

With more butter on the market again and with the point value reduced, the sanatorium is now free to serve its usual generous portions of butter. Immediately the supply increased, the patients lost interest in butter and now their trays come back with considerable unused amounts, which in a hospital for the tuberculous naturally cannot be put to any further use.

Thus we see that psychology plays a large part in the attitude of human beings, especially the sick ones, toward food shortages. If the butter slicer could have been adjusted so that thinner slices rather than half slices could have been served, the cubic content of butter being identical, there would probably have been little protest.

Turning to the final question "Do you use nonrationed foods extensively and, if so, what nonrationed foods are popular?" it was surprising to learn that only 40 per cent of the respondents make more than moderate use of nonrationed items.

Mrs. Edwina B. Mielenz, head of the 70 bed Ivinson Memorial Hospital, Laramie, Wyo., reports that nonrationed foods are scarce in that community most of the year. By this we suspect she means fresh fruits and vegetables and fish, perhaps poultry as well.

Catharine Stuart, the dietitian at Henry County Hospital, New Castle, Ind., writes that it is a difficult proposition to convince the hospital staff of the necessity for meat substitutes. She uses chiefly eggs, chicken and domestic rabbit.

Supt. Mellicent J. Mapes of the 65 bed Memorial Hospital of Greene County, Catskill, N. Y., has worked out this weekly schedule: Sunday, chicken; Monday, vegetarian dinner; Tuesday, meat; Wednesday: chicken pie made from left-overs from Sunday's chicken; Thursday, meat; Friday, fish, and Saturday, meat.

Fresh fruits and vegetables are the salvation of dietitians in meeting rationing problems. Community Hospital at Medford, Ore., makes use of home canned fruits and vegetables.

The 22 bed John Randolph Hospital of Hopewell, Va., lists as popular nonrationed foods "poultry, fish, fresh hot breads, home-made soups, fresh vegetables, dry beans and peas, macaroni and spaghetti."

Annie Laura Reid of Phoebe Putney Memorial Hospital, Albany, Ga., lists "fresh citrus fruits, fresh vegetables for cooking and salads, gelatin, eggs, prunes, raisins, whole grain cereals and enriched breads."

Several administrators and dietitians have been good enough to send in the following recipes for meat substitute or meat stretcher dishes that have achieved great popularity in their hospitals.

Cheese and Corn Soufflé

(Yield: 20 Servings)

3 ounces minute tapioca
1½ teaspoons salt
1½ pints scalded milk
12 ounces grated American cheese
7 (4½ oz.) well-beaten egg yolks
1 pint canned corn*
2 teaspoons grated onion
2 ounces (½ cup) chopped green pepper
2 ounces (4 T.) finely cut pimiento
7 stiffly beaten egg whites

(Yield: 50 Servings)

7½ ounces minute tapioca
3¾ teaspoons salt
3¾ pints scalded milk
1 pound 14 ounces grated American cheese
18 (12 oz.) well-beaten egg yolks
1¼ quarts canned corn*
5 teaspoons grated onion
5 ounces (1¼ cups) chopped green pepper
5 ounces (⅝ cup) finely cut pimiento
18 stiffly beaten egg whites

Add minute tapioca and salt to milk. Cook over rapidly boiling water for five minutes, stirring frequently. Add cheese and stir until melted. Cool slightly. Add egg yolks and blend. Add vegetables; then fold in egg whites. Turn into greased baking dishes, set in pans of hot water and bake in moderate oven (350° F.) for

*If kernel corn is used, drain and chop. Part of liquid may be substituted for an equal amount of milk.

NAPOLEON, in 1810, uttered the well-known cliche: "An army marches on its stomach"—and then two years later, forgetting all about it, stretched his supply lines 1500 miles into Russia to meet a terrible defeat.

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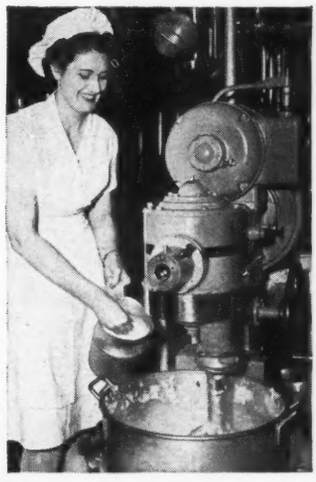
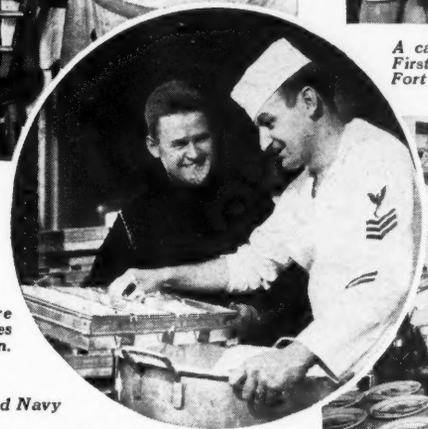
Navy cooks must learn how to use modern machinery in order to prepare the quantity and quality of food demanded by U. S. sailors.



A cake in the making at the First WAC Training Center, Fort Des Moines, Iowa.

Peeling potatoes at Chanute Field now requires two men, instead of a former dozen!



Batteries of Hobart Mixers prepare huge quantities of bread and pastries at Great Lakes Naval Training Station.

Photos released by U. S. Army and Navy

Typical galley of modern warship or merchant marine. These kitchens, with their up-to-the-minute equipment, are highest examples of efficiency in food service.

forty-five or fifty minutes, or until soufflé is firm. Or bake in greased individual custard cups in moderate oven thirty minutes, or until firm.—ERMA GREIG, *dietitian, Women and Children's Hospital, Chicago.*

***Mock Lobster Salad**

6 pounds fish
12 tablespoons oil
6 tablespoons vinegar (or lemon)
2 stalks chopped celery
¾ cup pickle relish
2 cups finely shredded carrots
Mayonnaise

Boil fish (halibut, haddock, cod or whitefish can be used) in salt water for ten minutes. Remove bones and pick fish into bits while still warm. Pour over the fish the oil and vinegar mixed together; set in cool place. When ready to serve, drain and add chopped celery, relish, carrots and enough mayonnaise to hold it together. Serve in lettuce cups, garnished with pimiento, parsley or paprika.—JANE NIMS, *dietitian, Methodist Hospital, Gary, Ind.*

American Spaghetti

(Yield: 75 to 100 Servings)

15 pounds ground beef
6 boxes spaghetti
1 gallon ready-to-serve spaghetti sauce
Season to taste
Grated cheese

Method: Brown ground meat and onions, add spaghetti sauce and simmer for several hours. Boil spaghetti until tender. Drain off water. Place ring of spaghetti on plate and add ring of meat and sauce combined. Sprinkle with imported sharp cheese.—ANNIE LAURA REID, *Phoebe Putney Memorial Hospital, Albany, Ga.*

Batter-Bread and Sausage Casserole

Place two small sausage links in each individual casserole and bake in oven until partially done or until batter for batter-bread is prepared. Remove from oven, take out sausages and fill casseroles half full of batter. Place partially cooked sausages on top of batter and return to the oven to bake batter-bread, the recipe for which follows:

To each quart of salted white corn meal in mixing bowl, add enough boiling water (about a pint) to moisten well. Make a very soft batter with buttermilk or sour milk and two eggs (per quart of meal). Add scant teaspoon of soda to a little cold water to dissolve well and stir vigorously into batter. The sausage fat in the casserole serves as shortening. This casserole makes a fine supper dish for the staff and for patients not on special diets.—MRS. L. S. CONNELLY, *John Randolph Hospital, Hopewell, Va.*

Beef and Bean Loaf

(Yield: 20 Servings)

3 quarts (10 oz.) corn flakes
1¼ quarts (1 lb. 12 oz.) cooked dried beans
2½ pounds ground raw beef
5 (8½ oz.) eggs
1 pint milk
1 tablespoon (½ oz.) salt
1 2/3 tablespoons prepared mustard
1/3 cup (2½ oz.) minced green pepper
¾ cup (3¼ oz.) finely chopped onion

(Yield: 100 Servings)

3 pounds 2 ounces corn flakes
8 pounds 12 ounces cooked dried beans
12½ pounds ground raw beef
2 pounds 10 ounces (25) eggs
2½ quarts milk
2½ ounces salt
½ cup prepared mustard
13 ounces minced green pepper
1 pound finely chopped onion

Crush corn flakes into fine crumbs. Force beans through ricer or coarse sieve. Combine crumbs, beans, eggs, milk, salt, mustard, green pepper and onion. Mix thoroughly. Pack in greased loaf pans. Bake in moderate oven (325° F.) about one hour and twenty-five minutes. Allow to stand five or ten minutes before removing from pan.—ERMA GREIG, *dietitian, Women's and Children's Hospital, Chicago.*

Menus for August 1944

Helen B. Anderson
The Scripps Metabolic Clinic
La Jolla, Calif.

Recipes will be supplied by The Modern Hospital, Chicago

1
Rhubarb
Scrambled Eggs
•
Broiled Grapefruit
Fish Turbans
Escalloped Potatoes
Harvard Beets
Mixed Greens
Caramel Pudding
•
Split Pea Soup
Cottage Cheese
Spinach
Tomato Salad
Peaches

2
Orange Juice
Bacon
•
Vegetable Soup
Swiss Steak
Baked Potatoes
Asparagus
Celery Hearts
Watermelon
•
Oxtail Soup
Macaroni and Cheese
Grated Carrot, Raisin Salad
Lemon Tarts

3
Prunes
Coddled Eggs
•
Cinnamon Apple
Baked Ham
Hominy
Baked Squash
Romaine Salad
Strawberry Shortcake
•
Tomato Okra
Baked Hash
Fruit Salad
Butterscotch Pudding

4
Canteloupe
Poached Eggs
•
Cream of Celery Soup
Halibut
Parslied Potatoes
Escalloped Tomatoes
Lettuce Salad
Orange Sherbet
•
Corn Chowder
Liver Lyonnaise
Escalloped Eggplant
Stuffed Apple
Burnt Sugar Cake

5
Baked Apple
French Toast
•
Dill Pickles
Meat Loaf
Corn on the Cob
Carrots
Chef's Salad
Upside-Down Cake
•
Bouillon
Creamed Ham
Bran Muffins
Cabbage, Peanut Salad
Cooked Plums

6
Grapefruit
Soft Boiled Eggs
•
Consommé
Chicken
Rice
Cauliflower
Olives
Fruit Ice Cream
•
Cream of Corn Soup
Cold Meat Plate
Lima Beans
Spiced Pear Salad
Sponge Cake

7
Figs
Ham
•
Green Tomato Relish
Pot Roast
Boiled Potatoes
Creamed Onions
Mixed Greens
Deep Apple Pie
•
Vegetable Soup
Minced Chicken In Brown Sauce
Biscuits and Honey
Celery Victor
Nectarines

8
Apricots
Scrambled Eggs
•
Vegetable Soup
Fish Loaf
Escalloped Potatoes
Asparagus
Pickled Figs
Peaches
•
Cream of Chicken Soup
Chinese Omelet
Molded Beet Salad
Fresh Pears

9
Apple Juice
Eggs Viennese
•
Bouillon With Rice
Oven Fried Chicken
Mashed Potatoes
Peas
Jelly
Lemon Snow, Custard Sauce
•
Cream of Spinach Soup
Fish Salad
Potato Chips
Escalloped Tomatoes
Applesauce

10
Orange
Bacon
•
Cream of Mushroom Soup
Sauerbraten
Noodles
Broccoli
Pickled Beets
Plum Cobbler
•
Jellied Consommé
Meat Balls With Spaghetti
Asparagus Salad
Raspberries

11
Persian Melon
Baked Eggs
•
Cream of Spinach Soup
Baked Swordfish
Potatoes With Lemon Butter
String Beans
Cucumber Salad
Fruit Compote
•
Tomato Bouillon
Chicken Pie With Potato Crust
Waldorf Salad
Gingerbread

12
Fresh Cooked Plums
Omelet
•
Consommé
Ground Round Steak
Baked Yams
Cooked Celery
Lettuce Salad
Berry Gelatin
•
Cream of Celery Soup
Hot Beef Sandwich With Gravy
Tomato Aspic Salad
Baked Pears

13
Grapefruit Juice
Canadian Bacon
•
Fruit Cup
Turkey
Rice Bread
Spinach
Celery Hearts
Peach Shortcake
•
Vegetable Soup
Corn Custard
Peas
Fruit Salad
Molasses Bars

14
Applesauce
Coddled Eggs
•
Pepperpot Soup
Short Ribs of Beef
Boiled Potatoes
Glazed Carrots
Romaine Salad
Caramel Custard
•
Cream of Vegetable Soup
Jellied Turkey
Lima Beans
Pear and Cream Cheese Salad
Icebox Cookies

15
Orange
Kippered Snacks
•
Cranberry Sauce
Chicken à la Maryland
Creamed Potatoes
Escalloped Tomatoes
Mixed Greens
Baked Pears
•
Consommé
Chop Suey
Noodles
Stuffed Egg Salad
Apricots

16
Casaba Melon
Soft Boiled Eggs
•
Barley Soup
Baby Beef Liver
Spoon Bread
Stuffed Eggplant
Pickled Beets
Lime Sherbet
•
Vegetable Juice
Fish Loaf
Baked Queen Squash
Cucumber Salad
Blueberry Cobbler

17
Youngberries
Scrambled Eggs
•
Applesauce
Roast Pork
Mashed Potatoes
Zucchini
Lettuce Salad
Fruit Gelatin
•
Cream of Pea Soup
Chicken and Rice
Molded Prune Salad
Oatmeal Cookies

18
Bananas
Soft Boiled Eggs
•
Lentil Soup
Salmon Steak
Parslied Potatoes
Broiled Tomatoes
Romaine Salad
Prune Whip
•
Apple Juice
Cheese Soufflé
Corn on the Cob
Mixed Greens
Peaches

19
Rhubard With Raisins
French Toast
•
Cider Ice
Braised Beef
Bread Dressing
Peas
Coleslaw
Rice Pudding
•
Rhode Island Clam Chowder
Asparagus
Melon Ball Salad
Orange Sponge Cake

20
Grapefruit
Bacon
•
Jellied Consommé
Turkey
Stuffed Potatoes
Mashed Turnip
Fruit Salad
Ice Cream
•
Barley Soup
Pork or Beef Sandwich
Escalloped Tomatoes
Waldorf Salad
Custard

21
Prunes
Shirred Eggs
•
Mushroom Soup
Spiced Ham
Sweet Potatoes
String Beans
Mixed Greens
Baked Apple
•
Consommé With Rice
Beef Birds
Potato Salad, Boiled Dressing
Youngberry Sherbet

22
Orange Juice
Scrambled Eggs
•
Broiled Grapefruit
Fish Turbans
Escalloped Potatoes
Banana Squash
Cucumber Salad
Peach Shortcake
•
Vegetable Soup
Turkey Tetrazzini
With Spaghetti
Coleslaw
Rhubard Cobbler

23
Honeydew Melon
Soft Boiled Eggs
•
Vegetable Soup
Chicken
Rice
Asparagus
Carrot Sticks
Orange Bavarian
•
Chicken Rice Soup
Ham Butts
Lima Beans
Grapefruit Salad
Caramel Cup Cakes

24
Figs
Bacon
•
Mint Sauce
Stuffed Lamb Shoulder
Corn and Pimiento
Russian Beets
Romaine Salad
Deep Berry Pie
•
Vegetable Cocktail
Chicken Sandwich
Peas
Olives and Celery
Fresh Pears

25
Tomato Juice
Poached Eggs
•
Mixed Pickle
Fillet of Sole
Mashed Potatoes
Summer Squash
Chef's Salad
Orange Sherbet
•
Corn Chowder
Cream Cheese
String Beans
Molded Prune Salad
Spice Cookies

26
Orange
Creamed Chipped Beef
•
Papaya Juice
Beef Tongue
Rice Bread
Glazed Carrots
Cabbage With Sour Cream
Gingerbread
•
Jellied Consommé
Shepherd's Pie
Biscuits
Mixed Vegetable Salad
Watermelon

27
Grapefruit
Scrambled Eggs
•
Vegetable Soup
Chicken Fried Steak
Sweet Potatoes
Zucchini
Mixed Greens
Youngberry Pie
•
Alphabet Soup
Cold Tongue
Creamed Potatoes
Chef's Salad
Grapes

28
Applesauce
French Toast
•
Melon Cup With Mint
Roast Lamb
Mashed Potatoes
Peas
Olives and Celery
Fruit Gelatin
•
Hot Fruit Soup
Croquettes
Corn on the Cob
Pear Salad
Butterscotch Pudding

29
Rhubarb
Coddled Eggs
•
Fresh Fruit Compote
Baked Shad
Baked Potatoes
Spanish Sauce
Asparagus
Jelly Roll
•
Cream of Spinach Soup
Cottage Cheese
Three Minute Cabbage
Tomato Salad
Fresh Peaches

30
Baked Apples
Bacon
•
Cranberry Ice
Rabbit
Escalloped Potatoes
Corn on the Cob
Lettuce Salad
Floating Island
•
Vegetable Soup
Minced Lamb in Brown Sauce
Noodles
Celery Victor
Fresh Pineapple

31
Canteloupe, Scrambled Eggs • Apple Juice, Roast Veal, Browned Potatoes, Spinach, Molded Beet Salad, Lemon Delicacy • Cream of Pea Soup, Rabbit Stew, Rice, Grated Carrot Salad, Loganberries

CONDUCTED BY W. W. DAVISON

Where to place FIRE EXTINGUISHERS

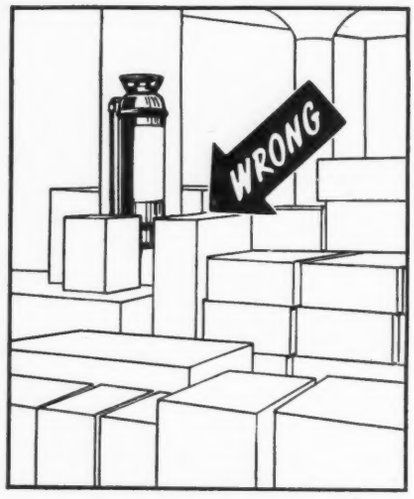
Extinguishers should be at the proper levels for ease of use.

THOUGH much has been written about how to choose the correct fire extinguisher and how to keep it in fire-fighting shape, little information has been given about where extinguishers should be placed with relation to fire hazard and occupancy. Many fatal and costly fires can be prevented if dealt with in their incipiency but, in order to win the battle with fire, the extinguisher not only must be the correct type for the hazard it guards but also must be properly placed in relation to the kind of property it is to protect and the contents of the building.

Here are six good rules to follow in the placement of extinguishers presented by an authority on the subject:

1. **Locate close to likely fire hazards.**
2. **Place so that fire will not block access to them.**
3. **Locate enough units to deal with the severity of the blaze which might be expected, the rapidity with which it might spread and the intensity of heat.**
4. **Locate conspicuously so that everyone will be familiar with locations.**
5. **Identify each unit for the type of fire it is designed to combat.**
6. **Protect from traffic. Don't put extinguishers unprotected in aisles where passing trucks and dollies will damage or knock them out of place.**

An extinguisher can be useless if it is located where precious seconds are lost in getting to it and back to the fire. It should be easily accessible for immediate use following the discovery of a blaze. For instance, in a machine shop, put extinguishers where they will be handy in case of fire in oil or motors. Don't locate them where spill fires are most likely to occur; remove them just a little and somewhat out of the direction of flow of the spill. Don't always place extinguishers at the end of aisles and don't locate them in stairwells. Flue action fans fire, preventing access to equipment.



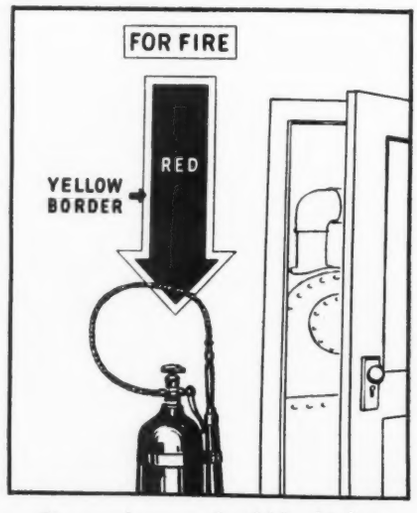
Don't put equipment where obstructions prevent quick use.

In the case of light hazard occupancies, where incipient fires of minimum severity might be anticipated, units should be so located that a person will not have to travel more than 100 feet from any point to reach the nearest unit. At least one unit should be supplied for each 5000 square feet of floor area.

Most extinguishers *should* be placed so that their tops are not more than 5 feet above the floor. These include carbon dioxide units with capacities of 10 pounds or less; water under 5 gallons; foam vaporizing liquid under 2 gallons; loaded steam, soda acid, dry compound and water and sand pails. Pails, however, should not have their rims less than 2 feet above the floor. The 15 and 20 pound carbon dioxide, 5 gallon water, 5 gallon foam and 2 and 3 gallon vaporizing liquid types should have their tops not more than 3½ feet above the floor.

Carbon dioxide and vaporizing liquid extinguishers should be hung on hangers supplied by the manufacturer, while the others may be similarly hung or set on brackets or shelves. Wheeled extinguishers, added where extra hazards require, should be accessible and adjacent doorways and alleys should be kept clear to afford ready passage.

There are several ways to make the locations of extinguishers con-



Sign and arrow should be higher than extinguisher for visibility.

spicuous, well known and readily seen despite the excitement that normally attends the outbreak of fire. A large red spot painted on the floor or aisle under the location of an extinguisher or a vertical red band with yellow borders down a sidewall or column where equipment is located acts as a constant reminder. Lights of distinctive color or signs "For Fire" with arrows pointing to extinguishers also serve a useful purpose.

To identify a piece of equipment as to the type of fire it will combat, a decalcomania may be attached to it or a stencil applied to the wall. When two or more extinguishers suitable for different purposes are put in the same location, don't leave room for guesswork; mark them plainly.

Good housekeeping is important; in addition to protecting extinguishers from traffic, keep boxes, cartons or other material far enough away to allow ready access to all units. Also, see that extinguishers are not used for hat and coat racks.

Last but not least, instruct those responsible for the safety of others in the location of all units and acquaint them with the operation of each type of extinguisher.

May we present: Robert Healey

Engineer Extraordinary

MILDRED CZOCK
Oakland, Calif.

THE Children's Hospital of the East Bay in Oakland, Calif., has a one man answer to shortages of manpower and material. For almost sixteen years Robert Healey, maintenance engineer and superintendent, has used endless ingenuity in making something from nothing. The war has merely provided greater scope for his talent for making bricks without straw.

Among other things he has designed steam inhalators to go on the hospital radiators and has equipped the entire building with them so that children with bronchial and tracheal disturbances can have the benefit of steam without all the bother of old-fashioned croup kettles. The device is simple enough, consisting of an open vessel attached by a small tube to the radiator valve. Opening the valve a trifle allows the steam to escape into the vessel and thence into the room. Condensed moisture drips through a tiny hole in the bottom into a pan suspended just below.

To the vacuum return system of these versatile radiators, he has attached a suction device to provide relief for children suffering from upper respiratory infections. Just beyond the radiator trap he has inserted a valve from which a tube leads to a container. This, in turn, is attached to a long, flexible tube with which mucal purulent matter can be drained from the nose and throat, greatly increasing the comfort of the patient.

Whenever a doctor needs a special type of fracture frame, he sends for Mr. Healey, who has already made many. He also makes carefully fitted, hinged arm splints, the angle of which can be adjusted with a thumbscrew when the doctor wishes gradually to change the angle of an elbow bend.

During the recent poliomyelitis epidemic, Mr. Healey put together a container for hot packs heated by the steam system. To this he attached an electric wringer from an old washing machine, thus providing a convenient way of keeping immediately available the necessary supply of hot packs for the Kenny treatment.

Throughout the hospital evidences of Mr. Healey's ingenuity are frequent. In the boiler room, which is also his workshop, he has saved material and expense by attaching his drill press to one of the uprights of the steel ladder beside the boiler. He made his emery wheel with a secondhand motor and an old oil burner reduction gear shaft.

Up on the wards he has provided innumerable small devices to add to the comfort of the little patients and the convenience of the nurses. In the bathroom adjacent to one small ward, he has made a hinged table over the tub. When it is folded up out of the way, the tub can be used normally for bathing older children, but when it is down, it provides an ideal place to bathe small babies.

He has made "bed cradles"—frames to hold covers off patients, which are used a great deal in orthopedic work; foot boards that keep the weight of blankets from the feet of the children to avoid foot drop—used when patients are hospitalized over a long period.

The nurses find extremely convenient the wooden props he has made to keep the side of a crib part way up.

When carpentering is involved, Mr. Healey often has the help of J. R. McGregor, the 80 year old Scotch carpenter who loves to do things for "the little ones." Together they rearranged one large ward, moved cubicles for communicable disease cases up from downstairs, rearranged them and then built a big, sturdy play-pen so designed that it can be used as a conventional square in the center of the floor or separated into sections to fence in individual cubicles or one whole side of the ward.

All of these varied activities are, of course, in addition to Mr. Healey's regular work which includes the usual responsibilities of a building engineer.

ENGINEERS' QUESTION BOX

Maintenance of Laundry Equipment

Question: Should the laundry manager or the engineer have the responsibility for the maintenance of laundry equipment?

ANSWER: This question was extensively discussed at a joint meeting of laundry managers and hospital engineers during the Tri-State Hospital Assembly in Chicago. After extensive discussion which brought forth varying opinions, the consensus seemed to be as follows:

In some hospitals the laundryman does practically all his own maintenance of machines (greasing, oiling, repairing and putting on aprons). One advantage of this plan is that the spare time of this man can be used for other operations or he can be used as a night washman.

The disadvantage of having this kind of maintenance done by the laundry department is that when more important breakdowns occur the engineering department must be called in and then an argument is likely to result.

W. W. Davison voiced the opinion of the engineers when he stated that there is no more reason to have a laundryman doing maintenance on laundry machines than there is to have the cook maintain the kitchen equipment or the surgical supervisor maintain the surgical equipment. The hospital engineer is responsible for the maintenance of all mechanical equipment.

The replacement of aprons, padding and the like is, however, a laundry problem and the engineering department need not be involved, according to Mr. Davison. The laundrymen agreed, in general, with this idea.

The same division of responsibility is in effect at Michael Reese Hospital, Chicago, and its laundryman reported: "Since it has been in effect we don't have any troubles and our decrepit plant is running better than it ever did."

Twelve different grades of grease are used on laundry machines at Wesley Hospital, according to Joseph Champley, engineer. Every greasing or other operation performed on any machine (in the laundry or elsewhere) is recorded on a card so that a complete history of the maintenance of the machine is available at any time.

Mr. Champley reported that on his ironers he had changed the type of covers and put buttons on the rolls. As a result they can change a cover now in a minute or two instead of taking much longer. On the finish presses, the girls change pads and covers themselves: pads once a week and covers twice a week.

Conducted by Alta M. La Belle

Safety *Is Your Business—II*

DON C. HAWKINS

Executive Field Representative
St. Paul Mercury Indemnity Company

IN THE discussion published in the June issue we covered a few of the major causes of accidents, so let us now look into the matter of maintenance of the small things and the importance of regular inspections. A few examples will illustrate what we mean. Most operating lamps are heavy and they are suspended from the ceiling by some type of anchor. The lamps are turned and pulled constantly and this affects the anchors, but they are in a hard place to reach and are rarely checked. I know of three instances in which the lamps have fallen and in two of them patients were on the table below. It is evident that they should be watched and, if possible, the bolts or screws should be treated so they cannot come loose.

Heavy Heavy Hangs Over Thy Head!

In one hospital a loose pivot bolt on the head section of an operating table fell out and allowed the section and the patient's head to drop during an operation. A counterweight cable holding the tube on a large x-ray therapy unit came off when a loose bolt came out and dropped the heavy tube on a patient, with serious results. A door lock on an elevator was out of order several days and when a patient opened the door by mistake she fell down the shaftway to her death.

An endless list of painful and even fatal accidents continues to pay tribute to carelessness and neglect of these small matters. You would naturally think that the nurses or aides or porters would discover these loose or broken parts and report them at once for repairs, but this doesn't appear to be true. The nurses sometimes assert that they do report to the repair men, but the repair men make a counter claim.

While the buck passing goes merrily on we find broken stools, broken glass, dangerous lamp cords and countless hazards that need only minor attention but are getting no attention at all.

To eliminate this condition you should have a good workable system of reports and inspections that ensures proper and regular inspections of all equipment. Of the various plans we have seen in operation the use of the repair book seems as simple and sure as any. Each department is furnished with a small, inexpensive notebook. It is hung on a string at some central point in the department where it is easily reached. Every nurse is required to enter an order for the repair of any broken or damaged piece of equipment she discovers and she dates and signs each order.

A repair man visits each department every day and does the required work. When it is actually done he must so note in the book, with the date and his initials. In addition to this daily routine, a competent repair man should make at least monthly inspections of all equipment and report in writing to the superintendent.

This may seem like a lot of unnecessary detail, but, when properly done, it means little additional work, protects your property and avoids a great many accidents.

In any discussion such as this we cannot overlook the hazard of fire. As long as many of our hospitals are still of frame construction or are poorly protected it will remain as one of our most feared visitors. Nobody ever expects a fire, but fires continue to come and with a building full of bed-ridden and helpless patients I can hardly overstress your obligation to protect these patients. In obviating this danger you have two distinct jobs to do. The first is to eliminate every possible cause of fire and the second is to study your buildings, make plans for a quick and efficient evacuation and train your staff to carry out those plans. Your local fire marshal will be glad to help in both of these jobs.

You probably know many of the basic causes of fire, but it is a safe bet that many dangerous conditions exist in your hospital. Go over your attics and storerooms carefully. Throw out the old junk and paper and obsolete furniture. If you do a good job you will probably have some room you need for other purposes.

A few weeks ago I visited the ruins of a hospital that had just burned to the ground. The cause was thought to be either a cigaret carelessly thrown in the trash chute or junk in the attic. Probably, if the attic had been clean and the trash chute had been lined with metal and equipped with a metal fire stop and with metal-lined self-closing doors the fire would not have spread.

Clean It Up; Clear It Out

Improper electric wiring is extremely common. Spontaneous combustion makes it important not to allow rags or waste to accumulate in dark corners or closets, especially in janitors' closets or paint rooms. These and many other hazards can be cleared up easily if you really want to make your hospital safe.

The major protective devices such as fire doors, fire walls and sprinkler systems require expert advice and your fire insurance companies will be glad to furnish it. There is no excuse for not finding out the conditions in your hospital and certainly none for allowing them to exist when so many lives are at stake.

In making plans for the emergency of a fire in any one hospital there are no general rules because no two institutions are alike. You should determine how a fire is most likely to act in your buildings and the best way to get the patients out. Train the staff in how to give alarms and how to fight fire.

In one hospital the director remarked that no fire could gain headway in his place because he had bought plenty of extinguishers. At a meeting of his nurses later we found that only three out of 42 had any idea of how to work the extinguish-

From a paper presented to the housekeeping section, Tri-State Hospital Assembly, May 1944.

ers and only one actually did a decent job when we made a test.

Some large hospitals have monthly fire drills during which every employe goes to a predetermined station and carries out the duties assigned to him. Unless you have a modern fireproof plant this system could save you a heavy loss.

While you are on the problem why not throw out those dainty little ash trays that hold about one cigaret and give your patients some big practical ones?

A hospital will always present a certain amount of risk to its patients and it should have all the legislative and insurance protection possible. On the other hand, neither you nor the medical profession can expect much help from an aroused public opinion to protect you against your own negligence or blundering carelessness if you prefer to follow the path of least resistance.

Too often, we hear the remark that there is no need to worry as liability or malpractice insurance takes care of the claims. Quite true, it does pay the claims, but it pays them with the hospital's money. Insurance companies cannot print the money and they are not charitable institutions. If your claim costs increase, your insurance cost goes up too.

You have a problem and its solution is not difficult. What it needs is some application and some action. You may or may not be fortunate in having a modern physical plant, but whatever your plant is you have with it the obligation to do your part in making it safe.

Biennial Congress

By JANE BARTON

ALTHOUGH war-time transportation and the difficulty of leaving their housekeeping duties for even a few days prevented many members of the National Executive Housekeepers' Association from attending the biennial congress in Philadelphia June 1 and 2, the 100 or so members in attendance enthusiastically voted the session one of the most worth while in the organization's fourteen years of existence.

Inevitably the spotlight was focused on personnel problems, with postwar trends running a close second as a subject of general interest.

The opening session on Thursday morning was devoted to a discussion of the War Manpower Commission's job relations program, which was interpreted by Russell Conard.

On Friday morning, Supt. Frank B. Gail, West Jersey Homeopathic Hospital, Camden, N. J., and Lucy Fogarty of the *Hotel World Review* served as coordinators on an "Information Please" program. Such questions as causes of absenteeism (and its prevention), methods of effecting further economies in manpower and materials and ways of getting more work done by fewer employes were discussed by a panel of experts.

One method of reducing absenteeism reported to be reasonably successful was a system of awarding certificates for perfect attendance for a period of three weeks. When several certificates have been accumulated the employe is entitled to a day off.

Four speakers were presented at the Forum on Postwar Trends on Friday afternoon. Gordon Chipman, director of training of the Statler hotels, discussing personnel, reported that for the last six months the Hotel Pennsylvania, New York City, has held special train-

ing classes for chambermaids. The classes are from four to six days in duration and, thus far, 200 maids have been trained. Although it is too early to evaluate the results, Mr. Chipman pointed out that maids who have had the special training stay two or three times as long as do those who have not.

The speaker also reported the issuance of a job training manual by the Statler Hotel in Boston, which is to be used for teaching bathmaids and chambermaids.

Fluorescent light is the light of the future, it was predicted by A. S. Turner of General Electric Company. Mr. Turner deplored the use of the term "fixtures" in connection with lighting because it implies immobility, whereas he prophesies that lighting equipment of the future will be highly mobile and flexible. For example, Mr. Turner predicted that such furnishings as beds, dressing tables and chairs will eventually have lights built into them. He also suggested the use of lights of various colors to create desired decorative effects.

"Decoration that doesn't make sense from the housekeeper's point of view isn't good decoration," declared Raymond P. Sloan, editor of The MODERN HOSPITAL, a statement that earned him a round of applause.

Discussing trends in interior decoration, Mr. Sloan warned that while there will be many changes they will come gradually and all innovations must be proved useful before they will be accepted. He emphasized the beauty that is to be found in simplicity and predicted that in future buildings there will be more streamlining in both architecture and furnishings and less interruption of surfaces.

Beauty in institutions is not difficult to attain, the speaker asserted. He suggested that before any large decorating project is undertaken the services of someone who is an expert on color and also understands the needs of hospitals be enlisted.

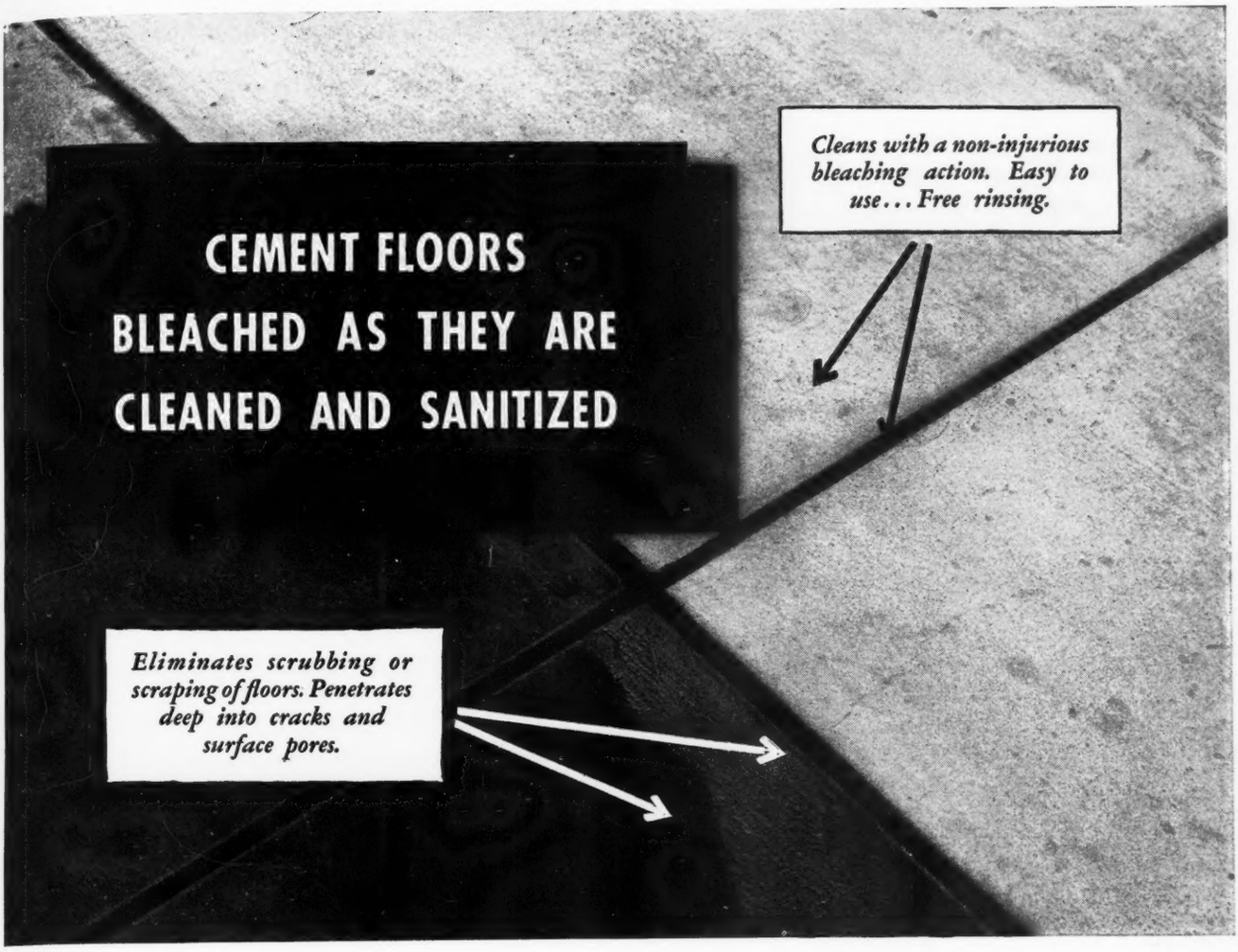
The right and wrong ways of doing things were illustrated in a series of sketches exhibited by Mrs. Crete Dahl of the Hotel Management Employment Training Service. Mrs. Dahl urged that housekeepers and other department heads study the work done in their departments and the equipment and supplies provided for the workers with a view to making the work easier and removing the minor irritations that make an employe's work harder than it needs to be. She suggested that many inventions now used to impress guests and patients will be put to work for the benefit of employes. These will include the "magic eye" for opening doors, air conditioning for laundries and kitchens and proper lighting in all work spaces.

During the business session of the association, it was voted to promote a concerted drive to improve educational standards for housekeepers. An education chairman will be appointed by each local chapter and it will be her responsibility to keep the national chairman informed of the activities of her group. Eventually, it is hoped to work out a series of regional institutes or refresher courses and also to seek the cooperation of various universities in inaugurating courses directly pertaining to housekeeping.

The principal speaker at the closing banquet was Dr. Donald C. Smelzer, administrator of Germantown Hospital, Philadelphia, who urged closer cooperation between the housekeepers' association and the American Hospital Association.

New officers elected for the ensuing two years are as follows: Myrtle Stevens, executive housekeeper, Kridell Hotels, New York City, president; Delia Tellin, Thames Manor, Pittsburgh, vice president; Mary Agnes White, Hotel Pierre, New York City, secretary, and Edythe Bussey, Schenley Apartments, Pittsburgh, treasurer.

The 1946 congress will be held in Columbus, Ohio.



Turco Aktiv Does These *Three* Important Jobs in *One Simple Operation*

Turco modern chemistry has produced in Aktiv a specialized cement floor cleaner that is exceptionally effective. Not only does it speedily and thoroughly emulsify grease and oil, it penetrates deep into cracks and surface pores, ordinarily uncleanable. The dirt comes to the surface where cold water will flush it away without trace. But that's not all: Turco Aktiv also sanitizes as it cleans, whitens cement with a non-injurious bleaching action.

A granular material, Aktiv is safe and pleasant to use at all times. As it dissolves completely in water, it may be made into a stock solution for use as needed. Or sprinkle it on a wet floor and, in a few minutes, lightly work into cracks and rough spots with broom or brush, hose off or mop with clear water. Hard scrubbing or scraping is eliminated. *Aktivating* cement floors is very inexpensive. Let the Turco Field Service Man show you. Write today.

Other Specialized Turco Products for Institutional Maintenance

Blu-Fax, for light duty cleaning of floors, walls, and factory equipment.

Lustrite, for safely cleaning linoleum, composition and rubber tile.

Tile-O, for bleaching ceramic tile, terrazzo, porcelain. Removes rust stains and hard water spots in washrooms.

Glyst, for cleaning windows and other glass. It is not oily; leaves no film.

Turco-Pine, a high concentrate pine oil disinfectant. Long-lasting. Demonstrated germicidal qualities.

Grip-Wax, for quick application. Immediate high polish without buffing. Anti-skid surface. Inexpensive. For floors, desks and other furniture.

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I'M NOT BUDGIN' TILL WE GET ONE THING SETTLED
AMBULANCE
871A-01
1.

INTERNE: Look, bub—you're a measles case, see? Your wife doesn't want you near the kids, see? So you're going up to a cozy little hospital bed, see?

VOICE: My good man, I *do* see! But I refuse to be dragged another half-inch till I learn what's for breakfast!

INTERNE: Look, Measles! We'll take it up with the dietitian as soon as you *come inside!*

VOICE: If that's a promise, I'll go quietly. But, mind you, you'd better really *tell* her about these lip-smackin' cereals. That they're all "Basic 7" foods, chock-full of *whole-grain* nourishment. That they come in *great big packages* as well as one-portion containers. That . . .

INTERNE: Breakfast! Are you balmy, mister? You'll probably get *cereal* for breakfast. So what?

VOICE: So this, Muscles. Either I get the cereals my Little Woman serves or I go back home, measles or not! After all, as long as you're serving cereals, why not serve those super-duper General Foods cereals? POST TOASTIES, GRAPE-NUTS, GRAPE-NUTS FLAKES, POST'S BRAN FLAKES, or hot GRAPE-NUTS WHEAT-MEAL. Man, they're the fastest-growin' cereal line in the country! Almost everyone *loves* 'em!

INTERNE: All right, Man Mountain, but would you mind explaining where you picked up all this fine lore?

VOICE: Where I *picked* it up! Why man, I *am* a dietitian! I gotta know my cereals! And as long as I'm strong for cereals I figure it's just plain horse sense to serve folks *the kind of cereals they eat at home.*

Serve 'em the kind they eat at home!

General Foods Cereals

GRAPE-NUTS • POST'S 40% BRAN FLAKES • POST TOASTIES • GRAPE-NUTS FLAKES • hot GRAPE-NUTS WHEAT-MEAL

NEWS IN REVIEW

American Nurses' Association Urges Wider Use of Negro Nurses in War Effort

Important resolutions adopted by the various sections of the American Nurses' Association at the biennial convention in Buffalo, June 4 to 8, have been referred for action to the board of directors and are not yet available for release.

Katherine J. Densford of the University of Minnesota was elected president of the A.N.A., Ruth Sleeper of Massachusetts was chosen president of the National League of Nursing Education and Marion Sheahan of New York City was named president of the National Organization for Public Health Nursing.

Criticism of the action of the A.N.A. in encouraging the development of auxiliary nursing service was answered by Maj. Julia C. Stimson, president, who said that "if the nursing profession as a profession had refused responsibility in so vital a matter, some other group would have undertaken it and a growing section of our function would have been out of our hands."

She also reported that a joint committee of the A.N.A. and the A.H.A. had been appointed to study personnel practices and salaries for nurses in hospitals.

Negro nurses are not being fully used in the war, Elmira B. Wickenden, executive secretary of the National Nursing Council for War Service, reported. "The Navy does not enlist them and the Army has only 217 at the moment." Mrs. Wickenden said that the council has urged both the Army and Navy to use Negro nurses and has presented extensive evidence of satisfactory results in nursing schools enrolling both Negroes and whites. The council's consultant on Negro nursing has been making a countrywide effort to increase and improve the educational and employment opportunities of Negro nurses.

Looking to the future, Mrs. Wickenden said that "there seems to be no question of the need for as many nurses as we have now or shall have after the war, at our present rate of student admissions. But knowing this fact does not automatically prepare, place or pay for these nurses where they will do their best work or the most good."

The N.O.P.H.N. adopted a resolution urging the expansion of public health nursing to cover the entire country, urban and rural and regardless of economic status, creed or race. The resolution suggested one nurse to each 2000 or 2500 people. This would require the expansion of the present 21,000 public health nurses to 60,000 or 65,000.

New Oil Treatment Decreases Respiratory Ills

By EVA ADAMS CROSS

WASHINGTON, D. C.—An odorless, greaseless, nonsticky oil treatment for floors, blankets and bedding to trap germs in hospital wards and barracks has been developed in researches carried out by medical scientists for the Office of the Surgeon General, the War Department announced May 27. It is claimed that the new oil treatment holds the bacteria and viruses of infectious diseases so tightly they cannot spread into the air and it is hailed as a major advance in blocking the spread of respiratory ills.

Tests at Camp Carson, Utah, and neighboring Peterson Field covering 16,000 men indicate that respiratory ailments can be reduced 28 per cent by keeping the floors of barracks oiled and soldiers' blankets impregnated with oil film. In hospital wards, oiling the floors cuts air-borne bacterial counts from 460 to 120 per cubic foot of air—a decrease of 74 per cent. The oil treatment of bed linen has proved even more effective.

Oiling ward floors is a simple mopping process. The treated floors, costing only $6 per barrack, will trap germs for four months. The treatment for blankets costs 2 cents a blanket and will last at least two months. The invisible oil film adds from 1 to 2 per cent to the weight of the blankets, makes them warmer and leaves them with unchanged appearance, feel or odor. The Bureau of Standards tests indicated that the oil treatment adds no additional fire hazard to the blankets.

G.I. BILL OF RIGHTS

The "G.I. Bill of Rights" was signed by President Roosevelt on June 22. It declares that the Veterans Administration is "an essential war agency" and directs the administrator and the Federal Board of Hospitalization to complete the construction of additional hospital facilities as needed. The sum of $500,000,000 is authorized to be appropriated for the construction of additional hospital facilities.

W.P.B. Reduces Number of Forms to Be Filed

By EVA ADAMS CROSS

WASHINGTON, D. C.—In an all-out endeavor to reduce the number of forms hospitals must file, the former WPB-2814 series has been combined with the standard WPB-617 project application, W. S. Brines explained in an interview June 8. No longer is WPB-2814.1 the form number applied to preliminary applications for hospitals and related facilities.

The questionnaire portion is now numbered 617.1 and the cover sheet, formerly 2814, has been eliminated. This move does away with the so-called preliminary application heretofore available to hospitals for determination of essentiality prior to any expenditure entailed in architects' services, contractors' estimates and similar outlays.

Mr. Brines pointed out, however, that WPB-617.1 is identical with the former preliminary questionnaire. He said, moreover, that if any administrator wishes an informal decision as to the essentiality of a proposed project, the hospital section offers its services to such an end.

The administrator may write a letter describing as accurately as possible the estimated project including the approximate cost. The letter combined with carefully compared answers to Form WPB-617.1 (or 2814.1) will be analyzed by the hospital section and an informal reply will be given. This material can later be used if formal application is made and it will form the basis of the War Production Board's decision.

It is expected that the privilege will not be misused by administrators and that only after hospital officials have made a careful study and are thoroughly convinced of the urgent need will such informal requests be made.

W.P.B. Approves 12 Projects

WASHINGTON, D. C.—The War Production Board has granted approval for the following hospital construction projects costing $100,000 or more in the period from May 22 to June 10:

Jackson Memorial Hospital, Miami, Fla., $369,000; Franklin Square Hospital, Baltimore, $172,000; Rochelle Hospital, Rochelle, Ill., $123,600; St. Joseph's Hospital, Minot, N. D., $160,000; Norman Hospital, Norman, Okla., $156,000; Indiana University Medical Center, Indianapolis, Ind., $218,400; Insular Home for Insane, Rio Piedras, P. R., $123,738; Missouri State Hospital, St. Louis, $208,800; St. Cloud Hospital, St. Cloud, Minn., $133,000; Philadelphia State Hospital, Philadelphia, $539,980, and $121,000 (two projects); Louise de Marillac Hospital, Buffalo, $153,126.

Don't Get Your Hopes Raised; Supplies Are Low

By EVA ADAMS CROSS

WASHINGTON, D. C.—In answer to questions as to availability of numerous items of hospital equipment, W. S. Brines, chief of the hospital section, government division, W.P.B., said flatly in an interview May 27 that the situation is still tough. He ran briefly through a list of equipment and supplies:

The stockpile of *new household mechanical refrigerators* is sadly depleted and more rigid criteria have been adopted in making releases. Consideration is given to written applications (Form WPB-882) for this particular equipment for the most highly essential purposes. Hospitals may still ask for these refrigerators but they must have justification for asking. Ice refrigerators are available without purchase permit. Every effort is being made to maintain and keep in service mechanical refrigerators already in use.

Freon 12 continues to be in short supply. Inventories for repair parts for *refrigeration and air conditioning equipment* are dangerously low.

As for *floor maintenance machinery* of the heavy duty type, hospitals will come in for their share just as they always have. A program for production of limited quantities was announced May 20 but this does not mean that floor maintenance machinery will suddenly be easily available, hospitals are warned. Urgent needs have hitherto been met from a stockpile which has dwindled; urgent needs will continue to be met through limited production.

Limited resumption of the manufacture of *civilian telephone sets* has been authorized according to an announcement Mav 19 of the Office of War Utilities. The authorized production will not for some time even approach essential demand.

Typewriters are still hard to find. Applications for their purchase are now filed in the nearest W.P.B. field office, W.P.B. announced May 16 regarding amendments to L-54-c. These amendments were made in connection with the recent revocation by O.P.A. of its rationing order covering the sale of typewriters. The new amendments to the order will not increase the supply of typewriters available, it was pointed out.

Though *ambulances* still may be obtained, the situation with regard to civilian ambulance service may soon become serious, particularly in those sections of the country where bad roads are accelerating normal wear. Ambulance plans must wait on the plans of the automotive industry as a whole.

The *new textile order, M-317,* came out May 29. There is no change in it so far as hospitals are concerned.

Cadet Pledge Is Honorary, Nursing Division Reveals

By EVA ADAMS CROSS

WASHINGTON, D. C.—An announcement by the Division of Nurse Education, U.S.P.H.S., on June 6 clarifies several issues that may have given concern to schools of nursing. A comprehensive legal interpretation makes clear that the pledge signed by the cadet nurse when she becomes a member of the corps does not establish a contractual relationship between the cadet nurse and the United States.

The pledge is honorary and the inability or failure to fulfill it involves no breach of legal obligation. Consequently, schools of nursing may not, merely on the basis of the pledge, require refunds from students who were members of the U. S. Cadet Nurse Corps and have withdrawn. Funds which have been refunded by such a student may be repaid her.

If a corps member ceases to meet the academic or other requirements, including health standards, necessary for continuance of her studies leading to graduation, her membership in the corps shall be terminated forthwith by the director of the school of nursing. A cadet nurse may terminate her membership by addressing a resignation to the director; or her voluntary withdrawal without submitting a formal declaration of her intentions will be treated by the school as a resignation.

The matter of transfers of cadet nurses from one school to another is also considered. The Division of Nurse Education neither encourages nor discourages such transfers. It is expected that each school will be certain that the transferring students meet its scholastic, health and other requirements. Each case must be considered on its merits.

The rulings of the state boards of nurse examiners must be followed with respect to the admission of transferred students. By agreement between participating schools of nursing, a junior cadet nurse may transfer to the second school without interruption of membership in the U. S. Cadet Nurse Corps, but only if extramural credit toward graduation is given by the second school for the full period of her enrollment in the first.

O.D.T. Offers New Plan to Curtail Convention Travel

WASHINGTON, D. C.—Warning that 1944 threatens to be a heavy convention year despite numerous appeals for curtailment from O.D.T., the director of the Office of Defense Transportation has gone direct to government agencies for their help in a four-point travel conservation program, according to a statement May 31.

Many organizations planning conventions justify them on the score that government officials are to attend. In some cases the attendance of government officials provides the principal excuse for calling the convention.

The four-point travel conservation program asks that: greater use of mail, telegraph and telephone be made instead of sending a representative; that only one representative, rather than two or three, be sent if the presence of a personal representative is imperative; that travel on intercity public carriers during annual leaves be discouraged, and that any travel which leads to or augments heavy concentrations of travel be scrupulously avoided.

Floating Hospitals With Convoys

One of the most recent additions to the Navy's hospital facilities is the floating hospital that now goes to sea as part of regular convoy escorts. Containing bunks for 57 passengers and having complete hospital facilities, these boats (known as PCE [R] 853) will save many men the ordeal of long hours at sea without adequate medical attention. Like other PCE craft, the rescue ships are manned by seven officers and 100 men. They can remain at sea for long periods of time.

Nurse Education Division Sets Up Field Offices

WASHINGTON, D. C.—Field offices of the Division of Nurse Education, U. S. Public Health Service, are scheduled to open in July in New York, Chicago and New Orleans, Eugenia K. Spalding, associate director of the U. S. Cadet Nurse Corps, announced at the meeting on June 1 and 2 of the advisory committee to Dr. Thomas Parran on the U. S. Cadet Nurse Corps. Each field office will be under the supervision of a nurse education consultant, working with a public relations representative and an auditor.

The New Orleans office will be headed by Elsie Berdan. Included in this district are Louisiana, Alabama, Florida, Georgia, South Carolina, Mississippi, Tennessee, New Mexico and Texas. Mary Jenney is appointed for the New York office which serves Connecticut, Delaware, Maine, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island and Vermont. The Chicago office will be supervised by Jane Taylor and the states covered are Illinois, Indiana, Kentucky, Michigan, Ohio, Wisconsin.

Nurse education field offices will be opened in the next few months in the other Public Health Service districts.

Amendments Make Changes in Regulation CMP 5A

WASHINGTON, D. C.—Amendments May 30 made certain changes in CMP 5A. Hospitals of this country are little affected; the main purpose of the new policy is to extend to eligible foreign hospitals the privileges contained in this order.

The amended regulation also gives specific instructions to be followed by hospitals and other institutions seeking increased quotas. In making this application the following questions should be answered specifically:

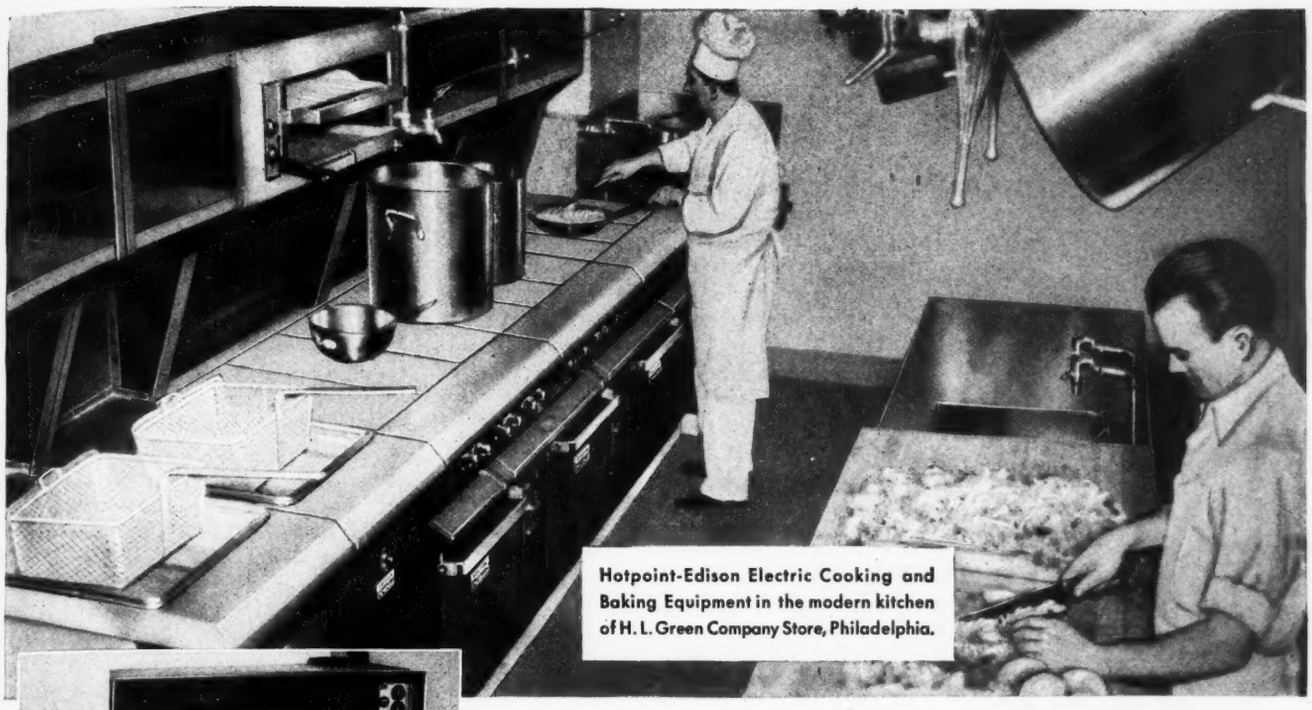
1. What were your MRO expenses during your base year?
2. If on a seasonal basis, what was the dollar volume per quarter of the MRO you ordered for delivery during your base year?
3. What are the dates of your base year and of your operating year?
4. How much have you spent for minor capital additions in each quarter of your current operating year?
5. What increase in quota have you had to date?
6. What amounts of increase (excluding labor costs) are necessary to your operations?
7. What are the specific facts justifying your needs for increase? Explain fully whether your needs for increase will be temporary or permanent.
8. If increase is for a specific operation which may not soon recur, between what dates will this operation be carried on?

New Cotton Bandage Developed

WASHINGTON, D. C.—A new type of all-cotton gauze bandage has been developed by the U. S. Department of Agriculture, according to an announcement June 3. The bandage is made by chemically treating ordinary open-weave gauze. It fits and clings better than ordinary gauze and allows greater freedom of movement in bandaged joints. A high degree of stretchability makes the bandage partly self-fitting so that it conforms to irregular surfaces. Its elasticity makes it flexible and somewhat self-tightening without restricting the circulation of blood and the roughened surface holds layers of bandage together in contrast to the slippperiness of ordinary gauze.

Straus Residence to Hospital

Heirs of the late Herbert N. Straus have presented the handsome Straus residence on East Seventy-First Street in New York City to the Roman Catholic Archbishopric. The house will be converted for use as a convalescent home in connection with St. Clare's Hospital, New York City.



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Long-life service comes from such wartime developments as rugged, metal-sheath Calrod units, with glass-sealed terminals. Switches are specially designed for heavy duty. Quality that means dependability is built into all vital parts. Less fire hazard — no flame or inflammable fuel. At first chance, whether now or later, go *modern* with Hotpoint-Edison Electric Cooking Equipment.

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RANGES • BAKE OVENS • ROASTING OVENS
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OLDEST AND LARGEST MANUFACTURERS OF ELECTRIC COOKING EQUIPMENT

FOR VICTORY — BUY U. S. WAR BONDS AND STAMPS

Veterans Administration Seeks More Physicians

WASHINGTON, D. C.—Because the need for physicians in the Veterans Administration has increased, the Procurement and Assignment Service of W.M.C. is reexamining the classification as to essentiality of physicians heretofore regarded as over age, W.M.C. announced on June 13.

All who can be spared without detriment to community health will be declared available for military service and given an opportunity to apply for commissions with the understanding that they are to be assigned to the Veterans Administration.

The Army now commissions physicians up to 63 years of age and the Navy up to 60. Physical qualifications have been relaxed for physicians coming under this program. Physicians who are essential should find their own replacements before availability is granted. Professional standards, rights, privileges and obligations of these physicians will be the same as for other commissioned officers. A physician may express a preference as to the branch of Veterans Administration service in which he shall serve.

Space Control Committee Set Up for Surplus War Property

WASHINGTON, D. C.—Admittedly nebulous though the surplus commodities picture may still be, it moved a little more into focus with the formation on June 4 of the Space Control Committee to coordinate the surplus war property storage activities of government agencies. Represented on the committee are the War and Navy departments, Maritime Commission, Procurement Division of the Treasury Department and the Reconstruction Finance Corporation.

Such property must be adequately safeguarded and protected in suitable storage facilities pending its disposal to private interests, William L. Clayton, Surplus War Property administrator, declared.

William Y. Elliott, newly appointed War Production Board vice chairman for the Office of Civilian Requirements, recently announced that O.C.R. will have membership on the Surplus War Property Board. This membership, he said, constituted recognition of O.C.R.'s important interest in the disposal of surplus war property.

W. S. Brines of the hospital section, W.P.B., stated that when the machinery for distribution is set up and surplus war property becomes available, his section will be "in there pitching" for the hospitals. He added that these surplus commodities will be sold at prices considered by authorities to be reasonable.

A.A.F. Convalescent Training Cited for Pioneer Work

WASHINGTON, D. C.—The Air Surgeon's convalescent training program which takes the soldier-patient out of bed as soon as possible and starts him on the road to recovery with bed exercises has been cited by the American Academy of Physical Education for pioneering in this field, the War Department announced June 3.

Said the citation in part: "For making available to the sick and disabled of our armed forces the latest discoveries and the finest services of both medicine and physical education, the American Academy of Physical Education takes pleasure in citing the Convalescent Program of the Office of the Air Surgeon."

The A.A.F. has established seven convalescent centers for the reconditioning and rehabilitation of casualties returning from overseas. Soldiers are taught in these centers the latest methods of overcoming disabilities and are given refresher courses for return to military duty or orientation and guidance before being discharged to civil life.

According to a report of the Air Surgeon, 80 per cent of the patients of the A.A.F. convalescent programs have been returned to duty since December 1942.

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FASTER, more efficient, more complete sales and servicing are in store for food merchandisers through this new U. S. Slicing Machine Co. service. For, through this nation-wide organization, you will get the combined benefits of the sales and merchandising experience of the two leading organizations in their fields . . . 131 years of food machinery experience that can help you meet today's needs and the challenge of postwar competition.

This new service is streamlined . . . it eliminates waste time. For you deal with only ONE experienced man . . . one man handles the complete lines of both companies. Keep your eyes on this combination; its big purpose is to be more helpful to you now and in the changing postwar days.

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2 INCREASED sales and merchandising help to aid you in meeting your local postwar competition.

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4 INCREASED customer appeal through improved design—U. S. and Enterprise products planned as matched units.

5 INCREASED, nation-wide service in parts and repairs that means quicker, more economical handling of your immediate needs.

6 INCREASED simplicity of financing through multiple-product sales that permit multiple-product financing with a single down-payment —simplifies your bookkeeping.

7 INCREASED research, development and engineering that assure improved equipment —more business.

8 INCREASED plant facilities and advantages gained from war production "know-how."

For complete information on these famous U. S. and Enterprise products, address our nearest office or write direct to U. S. Slicing Machine Co., La Porte, Indiana.

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New York State Association Offers Unusual Program

At its twentieth annual conference held May 24-26 at the Statler Hotel in Buffalo, the Hospital Association of New York State discussed problems of current interest and did some crystal gazing on its own. Added to a program of unusual interest were several innovations, such as a session devoted exclusively to the exhibitors during which hospital supplies and food were discussed by leading manufacturers.

In making the president's annual report Harold A. Grimm, superintendent, Millard Fillmore Hospital, Buffalo, referred to the success of the Emergency Maternal and Infant Care program about which some skepticism was originally expressed. "We are happy in the knowledge," said Mr. Grimm, "that it has been firmly established that the government should pay costs when purchasing hospital care. This is the pattern to be followed, we hope, in any future arrangements that may be made by government agencies."

Speaking on the use of voluntary hospitals for war casualties, he asserted that if we are to avoid a major hospital construction program on the part of the Veterans Administration, such as followed the last war, it will be necessary for voluntary hospitals to offer something as an alternative. "If the voluntary hospitals could be assured of payment on a cost basis, such as we have received for the care of E.M.I.C. cases, and have a reasonably consistent percentage of occupancies," he said, "I believe they would voluntarily provide such expansion of the physical plants as might be necessary to care for many of the war casualties."

Here is the situation as it affects the procurement and assignment of nurses in New York State during the next year as presented by Ruth G. Hall, state chairman. "In general, the prospects are good provided everyone accepts the fact that we must adjust to less nursing care. Already, word has been received that the Army has reached its current goal of 40,000 but the total ceiling has been raised to 50,000. That means that 10,000 nurses must be supplied by the nation for the Army during the year beginning May 1, 1944. The Navy requirements of 500 nurses a month remain unchanged. New York State enrolled 6000 students during the current school year and is already graduating 3000 a year."

Continuing on the subject of nursing, John Hayes, superintendent, Lenox Hill Hospital, New York City, described the two major problems as (1) shortage and (2) changed conditions. Of the two, the greater is shortage.

Efforts to control luxury nursing have not been too successful. Doctors have helped to some extent but have not done enough and patients continue o demand special nurses. They have money and too little patriotism.

The records of a hospital must necessarily be accurate, according to Dorothy Pellenz, Crouse-Irving Hospital, Syracuse, N. Y. "Information on arrival, identity and location of incoming patients must be distributed as swiftly and accurately as possible. With the acute shortage of hospital help, such procedure is not easy.

"The system used at Crouse-Irving Hospital has been in existence for more than two years. One clerk is able to make typed notices for eight separate departments of the hospital in one operation, and the 'checking in' ordeal of the patient is reduced to one interview."

Comprehensive hospital service on a sliding scale basis was recommended by Allan B. Thompson, vice president and actuary, Associated Hospital Service of New York. This is helpful to the public, he believes, because it means that the patients know what the bill will be for the expected length of stay in advance and, in consequence, have less worry over financial matters. Blue Cross plans have data on many hospital cases of all types and can be helpful to hospi-

pitals that are using sliding scale charges for general patients.

Officers elected for the following year are: president, John F. McCormack, Presbyterian Hospital, New York City; first vice president, Lee B. Mailler, Cornwall Hospital, Cornwall; second vice president, Morris Hinenburg, M.D., Jewish Hospital, Brooklyn; treasurer, Jerome F. Peck, Binghamton City Hospital.

Plans Postwar Construction

Beth-El Hospital, Brooklyn, N. Y., has announced plans for the postwar construction of a 600 bed structure that is estimated to cost $1,000,000.

O.V.R. and Children's Bureau Urge Inclusive Rates

WASHINGTON, D. C.—The Office of Vocational Rehabilitation and the Children's Bureau on June 15 submitted identical memoranda to the state agencies cooperating in their programs of hospital care, suggesting that they obtain written agreements with the participating hospitals on an inclusive per diem rate.

The memoranda suggest that the following services be included in the inclusive rate: semiprivate bed (two or more beds per room), board and special diets, general nursing care, anesthesia, physical therapy, services of interns, residents and salaried medical staff men, occupational therapy, medical social service, emergency service, operating room, oxygen therapy, laboratory service, dental service, drugs, plasma, blood, serums, antitoxins, vaccines and other biologicals, dressings and supplies, casts, x-ray and fluoroscopy, radium therapy and ambulance service.

The O.V.R. suggests that the items not included in the inclusive rate be listed and might include special nursing, prosthetic appliances and blood purchased from donors.

Similar lists are suggested for outpatient service.

The two sets of state agencies are urged to cooperate with each other so that hospitals can submit identical audited reports to both.

Microfilmed Magazines Sent to China to Aid Students

The MODERN HOSPITAL is now microfilmed in its entirety and airmailed to China on publication. It is one of 84 medical and nursing journals similarly treated. These are the sole sources of information on modern medical practices and developments for the Emergency Medical Service Training School at Tung-an in Hunan Province.

The journals are microfilmed by the American Bureau for Medical Aid to China, a participating agency of the United China Relief, which is supported by the National War Fund. Fourteen copies of each journal are made. The American Bureau for Medical Aid to China has since 1942 had seven subscriptions to The MODERN HOSPITAL.

The bureau also microfilms specialized medical books and other technical books. Until the microfilmed journals and medical books started arriving in Tung-an, the training school there was formed to instruct students in methods of treating shock, burns, wounds and fractures that were used during the first World War, the National War Fund reports. Projectors have been sent to China, including a new type that can be operated on storage batteries.

Village Insures Employes

Hempstead, a village on Long Island, N. Y., was reported recently to be the first municipality in the country to insure all its employes against medical expense. The plan applies to 167 village employes and became effective on April 1. Employes are covered under the Medical Expense Fund of New York City. All medical bills for individuals with incomes of less than $2500 are covered; for those with larger incomes the protection is a cash indemnity and the patient may pay additional to the physician. The cost is $1.50 per month.

Review of Month's Events in Blue Cross Service

Events in the Blue Cross field last month included the preliminary steps toward the formation of a new Blue Cross plan in South Dakota, the formation of medical care plans in New Hampshire and Kansas (both to be affiliated with their local Blue Cross plans), completion of the consolidation of the two plans in Connecticut, appointment of five new directors to the Associated Hospital Service of New York to represent the subscribers, appointment by the Nebraska Hospital Association of a committee to increase the cooperation of hospitals with the Blue Cross plan and extension of benefits by the plan in Ashland, Ky.

At the South Dakota Hospital Association meeting in Sioux Falls on June 14 and 15, a committee headed by Edna G. Davidson, superintendent of Black Hills General Hospital, Rapid City, was appointed with power to act. The association nominated the Associated Hospital Service, Inc. of Sioux City, Iowa, to operate the state-wide plan in South Dakota.

Miss Davidson was also chosen as the new president of the association and George Kienholtz of St. Mary's Hospital, Pierre, was reelected secretary-treasurer. The director of public health education of the South Dakota state board of health outlined a bill for the licensing of hospitals in the state. Another bill for licensing practical nurses was discussed.

The New Hampshire Blue Shield, providing for two types of service (medical and surgical), will be represented by the New Hampshire-Vermont Blue Cross plan.

The Kansas Medical Society authorized its president to appoint a committee to form a medical service corporation to serve individuals with less than $1800 income per year and families with incomes up to $2400. It is anticipated that the actual operation of the plan will function in conjunction with the Kansas Hospital Service Association. Proposed subscription rates are 75 cents and $2.25 for individuals and families, respectively.

The Connecticut Plan for Hospital Care, Inc., and the Hospital Service Plan, Inc., of Norwalk were officially consolidated on June 5 into the Connecticut Hospital Service, Inc. Charles H. Holt was named as acting general manager. He has been manager of the former plan. The temporary board of trustees is composed of all members of both previous boards. Contracts will be carried on without change for the present. Twenty-two per cent of the population of Connecticut is now enrolled.

The five new directors of the Blue Cross plan in New York City include personnel directors and union officers.

The new council in Nebraska will try to win greater hospital cooperation with Blue Cross, enroll all eligible nonmember hospitals, educate the public and get in touch with prospective subscribers.

Associations Contribute Funds

Four state hospital associations have contributed funds to assist the work of their local nursing councils for war service, according to a statement by the National Nursing Council for War Service made on June 13. The four are New Hampshire, New York, South Dakota and Washington. In addition, individual hospitals in Maryland and New York have contributed. Also hospitals and local hospital associations have contributed to local hospital councils to support their student recruitment and procurement and assignment of graduate nurses.

Hospital administrators now participate in the national council's work and usually in the state and local councils also. Other funds of nursing councils have been raised from community chest and war fund sources, although most of the expenses are still borne by nurses.

Urges Coordinated Program for Care of Chronically Ill

A comprehensive program for the care of the chronically ill should be adopted by the Coordinating Committee on Care of the Chronically Ill of Cleveland, according to a report on a survey made by Mary C. Jarrett of New York City for the Benjamin Rose Institute. Copies of the report were received on June 16.

Of the estimated 13,000 persons in the county incapacitated by chronic illness, a total of about 4000 chronically ill of all ages in Cleveland requires institutional care, Miss Jarrett concludes. Of these, 1000 to 1300 should be in a hospital and the remainder in a home for the chronic sick.

A new hospital for chronic diseases should be built as a division of Cleveland City Hospital and it should be connected with the school of medicine of Western Reserve University for medical teaching and with a school of nursing for nursing education. It should be equipped for research. There should be a custodial division for patients who do not require active medical treatment, with twice as many beds as the hospital proper.

Miss Jarrett recommends that public institutions for the chronically ill should accept patients on a pay or part-pay basis because of the lack of such facilities for persons able to pay for their care.

"For older people who find difficulty in attending clinics, a demonstration might be made of a special medical clinic in the out-patient department of a general hospital, with a physician in charge who is interested in diseases of old age and a medical social worker who understands old people. A mental hygiene guidance clinic might be set up in connection with the medical clinic, which could serve those who need help in becoming adjusted to their illnesses and also other elderly people who need psychiatric advice," the report recommends.

Home medical service and housekeeping service are also recommended.

"There is urgent need to supplement the present licensing of proprietary nursing and boarding homes by a system of supervision by a trained professional staff, which would eliminate the disgraceful conditions now found and lead to proper standards of care. Other provisions should be made for 300 recipients of old age assistance now in these unsuitable places," the report says.

Hospital Establishes Fund for Consultation Fees

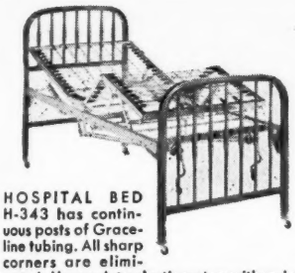
Trustees of the Delnor Hospital, St. Charles, Ill., have voted to establish a fund for specialist consultation fees, not only for charity cases but also for full or part pay patients to whom the cost of needed consultation service would be a real hardship. The fund is named the Lois McCornack Memorial Fund in recognition of the services of the late Lois McCornack as trustee, Red Cross nurse's aide and auxiliary worker. Limitation of the amount to be paid from the fund to each consultant has been fixed by the trustees.

"I believe a fund established for this purpose is unique and of interest to all hospitals not large enough to have on their staffs doctors in the various specialties," writes Cora Radke, superintendent.

Fellowships in Health Education

Qualified American women are offered fellowships for graduate work in health education by the U.S.P.H.S., according to an announcement of April 28. The funds were provided by the Kellogg Foundation for the term beginning next fall. A bachelor's degree is a prerequisite, and skillful use of English, courses in the physical and biological sciences, social sciences, education and educational psychology are desirable. The fellowships lead to a master's degree and carry funds for tuition, travel and $100 a month for living expenses.

SIMMONS HOSPITAL BEDS



HOSPITAL BED H-343 has continuous posts of Graceline tubing. All sharp corners are eliminated. Heavy duty plastic casters with spring clip sockets. L-101 Posture Bottom with end cranks.

BALKAN FRAME H-10 — Portable steel frames for fracture cases; fits any standard bed. Completely demountable—easily assembled.

CRIB HC-201— Sizes 30x54 and 36x60 inches. Maximum opening ends and sides 3 inches. Galvanized fabric spring. Plastic casters.

Here, in a complete line of hospital beds is every provision for the comfort of the patient! Doctor and nurse requirements were also carefully studied for types of design that would afford them greater convenience and efficiency.

For example: With the Simmons Deckert Bed, all adjustments are performed by *one* nurse—easily and quickly. No strain or inconvenience to the patient—comfort is not disturbed. All through the Simmons line—there is this comfort and efficiency in *every* Simmons Hospital Bed—every functional aspect of design has carefully been considered.

Features such as these make Simmons beds a necessary part of hospital equipment. And with most types *still available*, now is the time to talk to your Hospital Supply Dealer. Or, write the nearest Simmons office for complete information.

Shown at top is Simmons Standard Hospital Bed with Deckert Bottom for specialized purposes where multi-positions are desirable.

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A.H.A. and A.M.A. Agree on Principles of Relationship

The principles of relationship between hospitals and radiologists, pathologists and anesthetists, originally adopted in 1939, were reaffirmed by the American Hospital Association and the house of delegates of the American Medical Association. A joint committee representing the trustees of the A.M.A. and A.H.A. met on May 11 and its action was confirmed at the June A.M.A. meeting.

In addition the joint committee stated that medical and hospital prepayment plans should not be used as implements for upsetting established relationships between hospitals and these specialists. On the other hand, the proper growth of such prepayment plans should not be blocked by an insistence upon some one particular form of relationship between the hospital and the specialists.

Until experience has clearly demonstrated that some one type of arrangement is the best, hospitals and specialists are free to select the particular arrangement upon which they can agree, the statement says.

Thus hospitals can contract with these specialists on a straight salary basis, on a percentage distribution of gross or net income or on a rental arrangement. Neither party can force the other to adopt a particular plan by stating that all alternative plans are unethical.

Canadian Officials Study Health Service, Insurance

Canadian public health officials, including the Dominion Minister of National Health and the provincial ministers, held a three day conference on May 10 to 12 and agreed on major principles of health service and national health insurance.

Bills are to be introduced into Parliament and the provincial legislatures to carry out the plans agreed upon. The insurance plan will be compulsory and contributory, with the Dominion contributing $100,000,000, individual employes contributing $12 each and income tax levies to provide another $100,000,000; the Dominions will pay costs of administration plus the contributions for the indigents.

The authorities have rejected the principle of contributions by employers on the ground that they impose a burden on industry and would increase the cost of production.

Hospital Exempt From Tax

The claim of Doctors Hospital, New York City, that it should be exempt from city real estate taxes was upheld in a unanimous decision of the Appellate Division on May 12. The ruling reversed the order of the New York Supreme Court which on Nov. 27, 1941, held that the hospital had failed to qualify for exemption under the tax law because of "failure to extend adequate free service to the public." The hospital's claim involved taxes totaling about $500,000 for the years 1933 to 1939.

1200 Graduate From Sheepshead Bay

WASHINGTON, D. C.—More than 1200 pharmacist's mates have been graduated in the last year and a half from the Hospital Corps School of the U. S. Maritime Service at Sheepshead Bay, N. Y., the War Shipping Administration announced recently. Assigned to ships of the merchant fleet, these pharmacist's mates are safeguarding the health of the men of the American Merchant Marine.

Army Nurses on Red Cross Staff

WASHINGTON, D. C.—Two Army nurses have been added to the administrative staff of the American Red Cross in the Afro-Italian theater. They are 1st Lt. Margaret M. Cameron of New York City and 2nd Lt. Catherine Gray of Schuylkill Haven, Pa. They will supervise the health of almost a thousand Red Cross workers in North Africa and Italy.

MONA LISA (La Jaconde)
by Leonardo da Vinci . . . the most famous painting in the world . . . regarded for centuries as the supreme embodiment of the enigma of womanhood. Mona Lisa's mysterious, baffling smile has immortalized her for all time!

Perfection
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BECAUSE of its perfection of color and line . . . its air of romantic mystery . . . Mona Lisa is said by experts to be one of the world's most significant and perfect works of art. In the world of surgery, SKLAR surgical instruments are as nearly perfect as more than 50 years of specialized experience can make them. Only the highest quality materials and manufacturing skill go into SKLAR production. The surgeon knows that in SKLAR instruments he'll find what he's looking for: strength plus corrosion resistance . . . special qualities of hardness, toughness, resilience. Yes, SKLAR instruments have proved in more than a half century's performance that they're made to order for the surgeon's most exacting needs. . . . *Sold only through accredited surgical instrument distributors.*

A catalog of Sklar Stainless Steel Instruments will be provided on request

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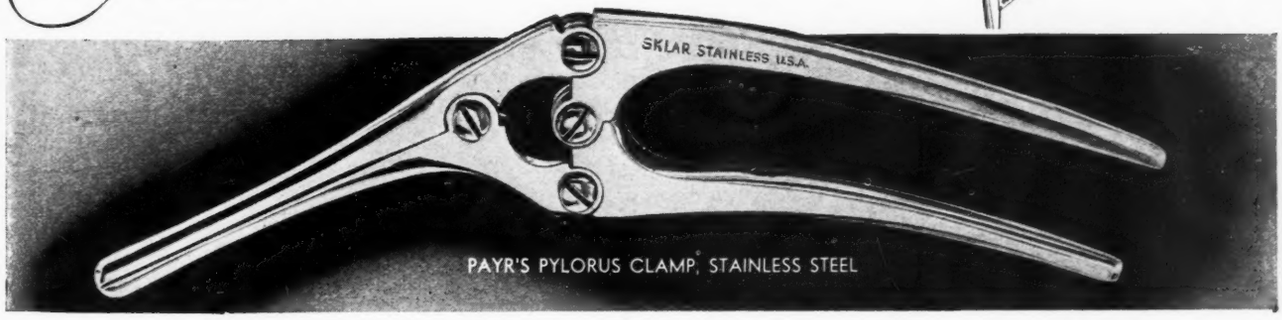

PAYR'S PYLORUS CLAMP, STAINLESS STEEL

V-D Treatment Belongs to Public Health—Baehr

"Rapid treatment methods for early syphilis, especially through the use of penicillin, make it possible for the first time to eliminate the plague and the time has come when federal, state and local public health authorities must step in and provide free treatment as a routine public health protective measure," declared Dr. George Baehr in an article in the State Charities Aid Association *News* of May.

The establishment of rapid treatment centers in many parts of the country is an example of what should be done on a broader scale. "Rapid treatment should be made freely available without charge to every person with early syphilis, on the one condition that the patient provide the health department with information which will enable it to bring the contacts under treatment. Rapid treatment with penicillin requires hospitalization for a week. Beds must be made available temporarily until the disease has been wiped out. The control of this widespread disease is now in our hands if we will place the responsibility for treatment wholly in the public health services and cease worrying about infringing upon the vested interests of the private practitioner," said Doctor Baehr.

He said that with penicillin 80 to 90 per cent of all patients with early syphilis can be rendered noninfectious within a week.

Griffin to Receive A.H.A. Award

Msgr. Maurice F. Griffin, senior trustee of the American Hospital Association, is to receive the association's annual award of merit at the Cleveland convention next October, it was announced by the A.H.A. officers on June 21. Monsignor Griffin is urban dean of the vicarage of Cleveland, East, and pastor of St. Philomena Church, Cleveland, a member of the joint committee of the American, Catholic and Protestant hospital associations, a vice president of the Catholic Hospital Association, a past president and treasurer of the Ohio Hospital Association, a member of the A.H.A. council on governmental relations and an honorary fellow of the American College of Hospital Administrators. He is a member of the editorial board of The MODERN HOSPITAL.

Excuse It, Please!

An article in the June issue of The MODERN HOSPITAL has been interpreted by some readers as implying that W.P.B. approval has been given to a hospital construction project in Ogden, Utah. Actually only F.W.A. approval and presidential approval have been given and at the time of going to press the project was still under study by W.P.B.

Council Issues Bulletin

The first issue of the *Bulletin* of the Hospital Council of Greater New York was issued in June. Among other articles in this four page bulletin is one describing a study of the 47 convalescent care homes in New York.

Coming Meetings

Aug. 25-26—Institutional Laundrymen's Association, Bellevue-Stratford Hotel, Philadelphia.

Sept. 6-9—American Congress of Physical Therapy, Hotel Statler, Cleveland.

Sept. 11-22—American College of Hospital Administrators Institute for Hospital Administrators, International House, Chicago.

Sept. 29-30—American Protestant Hospital Association, Hotel Statler, Cleveland.

Oct. 2-6—American Hospital Association, Hotels Statler and Cleveland, Cleveland.

Oct. 3-5—American Public Health Association, Hotel Pennsylvania, New York City.

Oct. 23-27—American College of Surgeons Clinical Congress, Stevens Hotel, Chicago.

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

Nov. 14-15—Kansas State Hospital Association, Wichita.

1945

March 19-21—New England Hospital Assembly, Hotel Statler, Boston.

April 11-12—Texas Hospital Association, Galveston.

NOVEMBER 14, 1666...

DR. SAMUEL PEPYS, in his famous diary, wrote: "*Here Dr. Croone told me that at the meeting at Gresham College tonight, there was a pretty experiment of the blood of one dog let out, til he died, into the body of another on one side, while all his own run out on the other side. The first died upon the place, and the other very well and likely to do well. This did give occasion to many pretty wishes, as of the blood of a Quaker to be let into an Archbishop and such like; but, as Dr. Croone says, may if it takes, be of mighty use to man's health, for the amending of bad blood by borrowing from a better body.*"

DR. PEPYS' notation that transfusion "may if it takes, be of mighty use to man's health" was surely prophetic, for today it is of tremendous therapeutic importance.

But the difficulties of typing and cross-matching where immediate transfusion is necessary pointed to a need for an acceptable blood substitute. Blood plasma was the substitute of choice and now, because dried plasma is not only stable and portable, but also because refrigeration is unnecessary, it is being used more and more wherever plasma is needed.

In addition to supplying Army and Navy requirements for plasma, Sharp & Dohme offer 'LYOVAC' Normal Human Plasma for use in civilian medical practice, using blood from professional donors . . . a project that makes 'LYOVAC' Normal Human Plasma ready for instant use wherever it is needed. Each 250 cc. unit contains approximately as much osmotically active protein as 500 cc. of whole blood.
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A development of Sharp & Dohme Research **'LYOVAC' NORMAL HUMAN PLASMA**

Thomas S. Gates to Head Commission on Hospital Care

Thomas S. Gates, president of the University of Pennsylvania, has accepted the chairmanship of the Commission on Hospital Care, it was announced by the A.H.A. on June 21.

This commission of 20 members is to conduct a two year study of the future of hospitals in the United States. Three grants, each of $35,000, have been made to the committee by the Commonwealth Fund, the Kellogg Foundation and the National Foundation for Infantile Paralysis. In addition, the American Hospital Association has appropriated $15,000.

Mr. Gates reports that he has received a favorable response to his invitations to membership on the commission sent to industrial, labor, political, agricultural and educational leaders. The names of other members will be announced shortly, as well as the commission's selection of a director of study and an associate director.

Mr. Gates is a former partner in J. P. Morgan and Company and Drexel and Company. He is a vice president of the American Philosophical Society, chairman of the advisory board for Region 2 of the War Production Board and a member of the national advisory committee of the American Red Cross. He is an attorney and former president of the Philadelphia Trust Company and a director of the Philadelphia Orchestra Association.

Greater New York Association Holds Annual Meeting

Some kind of prepayment method of health care must be devised to assure all of the people of New York City adequate protection. A. Newbold Morris, president, New York City Council, speaking before the annual luncheon meeting of the Greater New York Hospital Association, May 19, went on to explain that a number of plans had been presented, including that introduced recently by Mayor La Guardia, which he believes to have been advanced to stimulate discussion and eventual action.

Following the usual business meeting, which included various committee reports, the association elected the following officers for the coming year: president, Dr. Morris Hinenburg, executive director Jewish Hospital of Brooklyn; first vice president, Dr. Joseph R. Clemmons, director, Roosevelt Hospital, New York City, and second vice president, Rev. C. O. Pedersen, Norwegian Lutheran Deaconesses' Home and Hospital. George F. Holmes, superintendent, Memorial Hospital, continues as treasurer, with William B. Seltzer, superintendent, Bronx Hospital, serving as secretary.

A.H.A. States Policy

A policy statement setting forth the objectives of the American Hospital Association was adopted by the board of trustees in June. After a broad review of well-known facts and a reaffirmation of the policies adopted last year at Buffalo, the treatment urges rural-urban coordination of hospitals and declares that the present hospital system does not fully meet the needs of the public but states that in filling these needs four factors must be kept in mind. They are: (1) additional hospitals should be provided only where needed; (2) emphasis should be put on convenience and economy and on the utilizing of existing resources and organizations whenever possible; (3) all other factors affecting the public health should also be considered, and (4) the most pressing problems should be solved first, regardless of political expediency.

Blue Cross Admissions Up

A sharp jump in admission rates for Blue Cross patients for May was reported on June 17 by the Hospital Service Plan Commission. The rate of 105.3 admissions per 1000 (on an annual basis) was 8 per cent higher than the April rate or the rate for May 1943.

Needs of Old People Discussed by Geriatric Group

That the number of aged is increasing and that following the war when the manpower shortage ceases it will become a serious problem was emphasized by Dr. Wingate M. Johnson, Winston-Salem, N. C., before the second annual meeting of the American Geriatric Society held June 8-10 in New York City. The program was divided between sessions at the Hotel Commodore and clinics held at the Payne Whitney Clinic of the New York Hospital and the Polyclinic Hospitals.

Needs of old people for the future and the present are, according to Supt. Maxwell Lewis, Home for Dependents, Welfare Island, New York City: freedom of movement; freedom of worship; respect for personal possessions; the right of privacy; the right to immediate and proper medical care; the right to suggest ways for better care and to criticize; the right to a proper social and recreational life; the right to choose the type of institutional work desired; the right to be fed regularly with good wholesome food; the right to clean shelter; the right of proper and adequate clothing, and the right to safety of person.

What can be done to ease the burden of age through occupational therapy was described by Louis J. Haas, White Plains, N. Y. In order to make the changeover from active business life to retirement, it is necessary to provide a hobby. To feel a part of the community is essential to the happiness and self-respect of the aging person. Such hobbies, according to Dr. Edward B. Allen, White Plains, should be developed from early maturity as it is difficult to develop such interests when the mind is slower and there is less physical prowess.

Some words are as good as killers to old people. This warning was voiced by Dr. Malford W. Thewlis, Wakefield, R. I. As examples he cited arthritis, old age, angina pectoris and cancer. The correct philosophy can cause a person to live longer even with deadly diseases.

Civilian Specialists Aid Army

WASHINGTON, D. C.—The appointment of 19 civilian consultants to the Office of the Surgeon General as advisers to the Army Medical Department on problems of internal medicine was announced by the War Department on June 5. The consultants were selected from among the foremost authorities in eight special fields of internal medicine. The advice of these civilian advisers will supplement that of special consultants selected from officers in the Medical Corps; their work will be carried on through the chief consultant in medicine, Brig. Gen. Hugh J. Morgan, Medical Department, U. S. Army.

Importance of Group Leaders Emphasized at Conference

By MARGARET REAGAN

To emphasize the importance of the group leaders who voluntarily serve Blue Cross plans, the Minnesota Hospital Service Association, host to nine neighboring Blue Cross plans on May 25 and 26, chose as a luncheon speaker A. W. D. Stegner, one of the plan's oldest group leaders.

Speaking to approximately 70 plan directors and representatives, Mr. Stegner told how his company, the Webb Publishing Company of St. Paul, was one of the earliest groups to organize in Minnesota.

According to Mr. Stegner, a group leader has many opportunities to build good will for the plan among fellow workers and for making constructive suggestions to the plan, and he believes that the group leader, even more than the plan director or personnel, realizes the satisfaction and the appreciation subscribers feel after being hospitalized. Often Mr. Stegner receives notes or telephone calls from subscribers hospitalized in his group telling him how glad they are that they have Blue Cross protection.

A number of group leaders in St. Paul meet regularly for lunch and for a discussion of their group problems from time to time and a spirit of comradeship has been developed among them because of their common interest in the Blue Cross.

Hospital's Rule on Surgery Upheld by Florida Court

A municipal hospital has the right to prescribe qualifications for surgeons who wish to practice in the institution, the supreme court of Florida held in a recent decision.

A physician contended that the Mound Park Hospital of St. Petersburg, being supported by taxpayers' money, should permit any licensed physician to practice surgery without restriction if selected by a patient.

"When a municipality furnishes a hospital operating room and other facilities and is responsible to patients for the negligent use of these facilities, it has a right to know that they are placed in the hands of an expert," the court declared. "If this is not true, the city and the taxpayer have no protection whatever.

"It would project the doctrine of freedom and equality into unwarranted areas to hold that one could practice major surgery when he has nothing more than a diploma from a medical school and a certificate from the state board of medical examiners to warrant his skill in that field," the court said.

The physician is a member of the hospital's general staff.

Recommend Wide Changes in New York State Institutions

Changes to improve the departmental organization and procedure, education and research, physical plants, accounting and reimbursement by relatives or others for the cost of patient care are recommended in a report entitled, "The Care of the Mentally Ill in the State of New York" prepared by a commission appointed by Gov. Thomas E. Dewey. Copies of the report reached Chicago on June 21.

The commission was headed by Archie O. Dawson of New York City and the staff was directed by Christopher G. Parnall, M.D., medical director of Rochester General Hospital, Rochester, N. Y.

In addition to certain changes that have already been made by Commissioner Frederick MacCurdy, the report suggested that each hospital should have a department of clinical medicine, a department of professional care and a department of business administration. Examinations for superintendents and associate and assistant superintendents should be open to experienced hospital administrators outside the department. More psychiatric social workers, occupational therapists and nurses are recommended.

The hospitals should open their facilities for education in psychiatry to medical students and physicians and for research. A department of nursing to direct all nursing education and a departmental school for the training of practical nurses should be established.

Hospital Sunday a Success

Contributions to the 1944 Hospital Sunday fund of the Evanston Hospital, Evanston, Ill., reached a total of more than $33,000, according to a report made public on June 20. This is, by several thousand dollars, the largest amount ever raised in this annual appeal which has been conducted every February since 1898. More than 50 churches of all denominations in Evanston and the North Shore area participated this year.

O.E.S. to Build Hospital Wing

As their victory project for the coming year, 42,000 members of the grand chapter of Minnesota Order of Eastern Star will undertake the construction of a recreational wing at Fort Snelling Hospital, Fort Snelling, Minn. The unit will be a one story addition, 25 by 75 feet, with a sun deck. The O.E.S. embarked upon the project through the Red Cross camp and hospital council to provide the space and facilities needed by convalescent soldiers for recreational activities and entertainment.

Protestant Group Outlines Tentative Cleveland Program

A series of demonstrations in hospital administration at St. Luke's Hospital, Cleveland, under the direction of Dr. Fred G. Carter and his staff on Friday afternoon, September 29, will be the opening feature of the annual convention of the American Protestant Hospital Association, which occurs just prior to the American Hospital Association convention.

The demonstrations will cover personnel management, volunteer services, central control of supplies, pharmacy, laundry, interns and residents and nursing service and nursing education. It will be followed by a seminar for chaplains conducted jointly by Rev. Seward Hiltner of the Federal Council of Churches, New York City, and Rev. Russell L. Dicks, chaplain, Wesley Memorial Hospital, Chicago.

The Friday evening session will feature a round table conference by Dr. M. T. MacEachern and Robert Jolly.

Saturday's program will include addresses on nursing by Lucile Petry and David H. Spanier of the division of nurse education, U. S. Public Health Service, on interns and residents by Dr. Paul H. Barton of Procurement and Assignment Service and on the federal purchase of hospital service by Doctor Carter. The afternoon program will be a round table on the service of hospital chaplains. The Saturday evening banquet will be addressed by Congresswoman Frances Bolton on "Nursing Education During and After the War."

Fund Subscriptions High

Subscriptions from business concerns and employe groups amounting to $4,023,000 for the intensive part of the appeal of the Greater New York Fund were announced on June 9. This is the largest sum ever raised in a like period by the fund and constitutes 89 per cent of the goal of $4,500,000. It compares with $3,602,000 announced at a similar stage in the appeal last year. Hospitals in New York participate in this fund as well as in the United Hospital Fund receipts.

Nurses' Dormitories Opened

On May 6 Adelphi College, Garden City, L. I., opened the first buildings in the East constructed exclusively to train students of the U. S. Cadet Nurse Corps. Two dormitories for 200 students have been erected and equipped under a Lanham Act grant at a cost of $325,000, and include administrative offices, lounges, recreation and service rooms. Mrs. Franklin D. Roosevelt's address on "Nursing: a Necessity in War, an Opportunity in Peace," climaxed the program on the opening day.

OFFICIAL ORDERS

May 15 to June 15

Copper and Chrome.—Limited restoration of copper and copper base alloy products to replace steel in the manufacture of specified items of extended surface heating equipment, including blast-heating coils, convectors and unit heaters was announced May 16.

A new type of dental burr with a chrome finish will soon be put into production, W.P.B. announced May 19. It will last 50 per cent longer than the steel type now in use.

Electric Appliances.—Applications for new electrical appliances shall be filed on Form WPB-1319 with the nearest W.P.B. field office, according to an amendment of June 3 to Order L-65.

Electric Fans.—Production of 100,000 propeller-type electric fans, 12 and 16 inches in diameter, is to be permitted by W.P.B. according to an announcement of May 24. The number will be sufficient only to meet the most essential military, hospital and other needs.

Evaporative Coolers.—These coolers are again going into production, according to a W.P.B. announcement of May 19. This does not mean, cautions W. S. Brines, that they will be plentiful.

Heating Equipment.—Provisions have been made to allow production of more durable and satisfactory water heaters, hot water storage tanks and range boilers, W.P.B. announced on June 5. Production of hot water storage tanks was limited to 75 per cent of 1941 unit output. Copper for coils and tubing can now be used in place of cast iron.

Kitchen Equipment.—Annual production from July 1 of nonelectric commercial cooking and food and plate warming equipment and nonelectric dishwashers will be permitted. The food and plate warming and cooking equipment is to be manufactured at a rate of 72 per cent of 1941 production and the dishwashers at 92 per cent. The new quotas represent a large increase from the 25 per cent previously permitted but such equipment will not become plentiful.

Medical and Surgical Furniture.—Restrictions on the weight of metal permitted in the manufacture of certain items of medical and surgical furniture and related equipment were removed by W.P.B. on June 9, in an amendment to L-214, Schedule 3. This means that iron and steel will be substituted in place of wood, now a critical material. Not only can more satisfactory products be manufactured but items, such as bedside tables, swing overbed tables and bedside screens, will be more readily available. The amended schedule also removes restrictions on cabinets for diathermy units and cabinets for galvanic, faradic and sinusoidal generators.

Metal Furniture and Fixtures.—The amendment May 22 of L-13-a broadened the order to include a wider variety of metal furniture and fixtures. With certain exceptions the order as amended controls the production of any furniture and fixtures containing more than 5 per cent of metal by weight, other than the minimum essential amount of iron and steel required for joining hardware, and other than casters and upholstery springs. Manufacture of items falling within this classification is not permitted under the terms of L-13-a. There are certain exceptions.

Not controlled by the order are: time card racks (subject to L-54-c); medical and surgical furniture and related equipment (as defined in L-214, Schedule III); dental equipment; laboratory furniture; metal doors; metal door frames and metal shutters (subject to L-142), and metal household furniture.

The items previously permitted to be produced for general industrial, commercial and office use are still permitted to be made for such purposes. Among these items are wood filing cabinets and wood typewriter desks containing metal typewriter mechanisms.

Metal Lath.—Certain provisions governing the use of metal plastering bases and accessories were removed from L-59-b with an amendment on May 23. The sale of metal lath is now restricted to purchase orders bearing preference ratings of AA-5 or better and small orders of $5 or less. CMP 6, Schedule A, prohibits the use of metal lath and accessories in construction authorized by Form GA1456 for any purpose except that corerite, striptite, corner bead and flush base screed are permitted for interior use in hospitals and certain other buildings.

Metal Windows.—These may now be manufactured to fill orders with preference ratings of AA-5 or better, instead of AA-3 or better as heretofore, the W.P.B. announced on June 2.

Paper Cups.—All types of flat-bottom and cone-shaped paper cups and flat-bottom paper food containers of the round, nested kind have been placed under new production regulations since June 1. Hospitals, however, are still able to get them under CMP 5-A.

Quinidine.—W.P.B. on June 9 amended Order M-131 to permit the delivery of quinidine to an ultimate consumer on a prescription signed by a person licensed to prescribe drugs. Quinidine may be used only for the treatment of cardiac disorders.

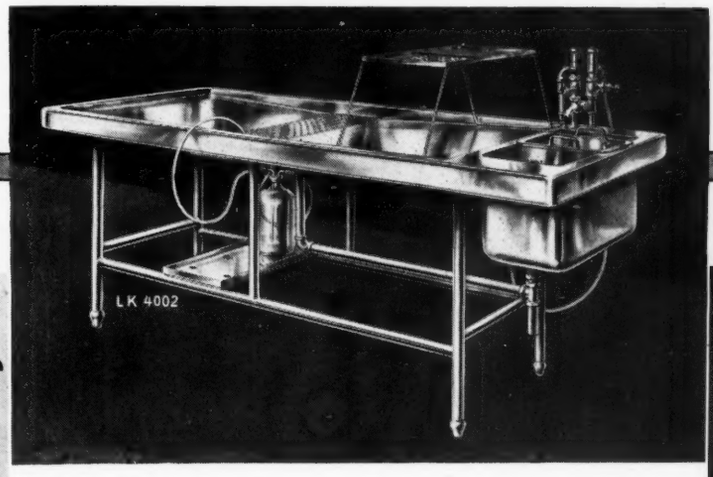
Refrigeration.—Applications for priorities assistance for refrigeration equipment other than industrial processing and air conditioning equipment have since May 25 been filed with local W.P.B. offices. Such applications should be made on WPB-1319 and are processed in the field. WPB-2448 has been discontinued. Applications for priorities assistance for industrial processing and air conditioning equipment will continue to be filed with the War Production Board in Washington on WPB-2449.

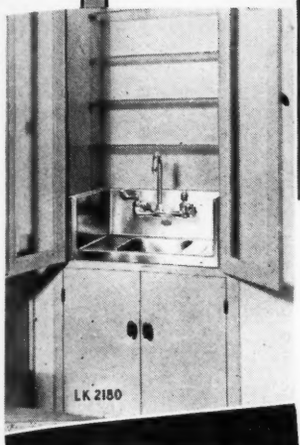
Sterilizer Equipment.—This equipment may be bought for use in approved construction projects when an authorization is given for the specific equipment on the project authorization (Form GA1456), W.P.B. announced on May 23. Formerly it was obtainable only on WPB-1319. The change was made to reduce the number of separate applications required in a construction project.

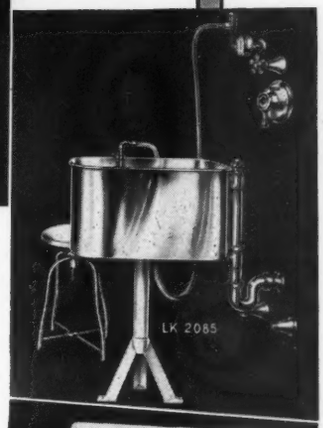
Tableware.—Use of copper and copper base alloy as undercoating for flat tableware and in lead plating has now been authorized, W.P.B. announced on May 26. Copper may also be used in bushings for hospital bedsprings.

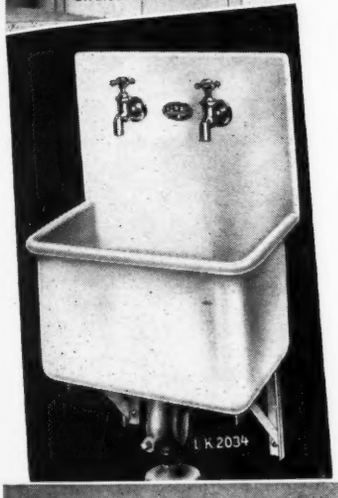
ELKAY *Sturdibilt* HOSPITAL EQUIPMENT

CUSTOM BUILT TO MEET INDIVIDUAL REQUIREMENTS









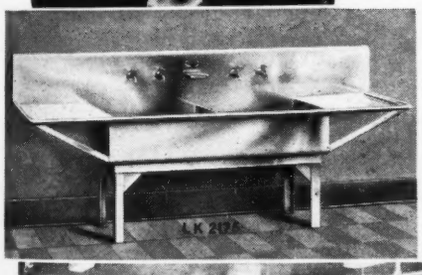
In presenting our line of ELKAY "Sturdibilt" Hospital equipment for Naval, Marine, Ground and Civilian use, we do so with a full appreciation of our responsibility and obligation to our Government and its citizens. Therefore, in the designing and building of this equipment we employ the services of outstanding technical experts. We feel that only in this way can we supply you with equipment that will meet your professional and technical requirements.

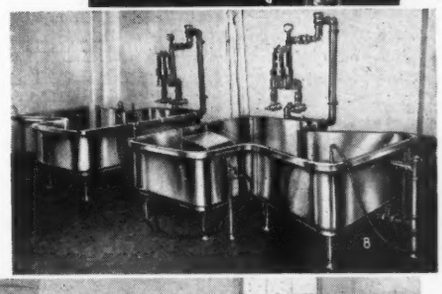
Among the many different items we manufacture are:

LK-2034 SERVICE SINK
LK-2062 PROPHYLACTIC TREATMENT STAND
LK-2068 LEG BATH
LK-2085 ARM BATH
LK-2175 SCULLERY SINK
LK-2180 NURSES' STATION SINK
LK-4002 AUTOPSY TABLE
5 CABINET TOPS installed in Wesley Memorial Hospital, Chicago
8 HYDRO-THERAPY TANKS installed in National Naval Medical Center, Bethesda, Md.
9 SINKS AND COUNTERS installed in Wesley Memorial Hospital, Chicago.

Any of these units can be supplied in either Stainless Steel, Monel Metal, or baked on white enamel.

We invite your inquiries and specifications. Our engineers will gladly submit plans and estimates.





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Northwestern Will Resume Administration Courses

Five evening courses in hospital administration will be given in the autumn semester of the program in hospital administration at Northwestern University under the direction of Dr. Malcolm T. MacEachern and five courses in the spring semester, it was announced in June. The autumn evening courses will open on September 20 with registration beginning on September 9. Registration for the spring semester opens January 27 with class work beginning on February 7.

The autumn courses are on "History and Development of Hospitals," "Organization and Management of Hospitals," "Professional Services to the Hospital Patient," "Legal, Political and Sociological Aspects of Hospital Administration" and "Fundamentals of Medical Science."

The spring semester courses are "Personnel Management in Hospitals," "Business Management of Hospitals," "Seminar in Hospital Administration," "Professional and Public Educational Functions of Hospitals" and "Fundamentals of Medical Science."

5,400,000 Industrial Workers Now Have Health Insurance

The growth of commercial group health insurance, paid for in part or wholly by employers, has resulted in 5,400,000 industrial workers having their health insured at a cost of approximately $61,000,000 a year under contracts with 15,700 employers, it was stated by Martin Segal on May 7.

Mr. Segal is president of the Trade Union Agency of New York City which serves as consultant to unions on group health and other group insurance programs. His agency provides hospital and surgical care insurance, accident and sickness benefits and death benefits.

Mr. Segal states that "group insurance plans, now frequently under joint labor-management administration, usually are underwritten by private insurance companies and Blue Cross plans." The Trade Union Agency helps unions to formulate health insurance programs to be included in contracts with employers.

Per Capita Costs in Jersey Hospitals

Average per capita cost in New Jersey general hospitals, counting new-born days as equal to ¼ adult days, was $5.66 in 1940, $6.03 in 1941, $6.57 in 1942 and $7.18 in 1943, rising to $7.87 for the final quarter of 1943. If infant days are omitted entirely the figures are: 1940, $5.86; 1941, $6.27; 1942, $6.89, and 1943, $7.52 with a final quarter of 1943 of $8.25. These figures were released in May by the department of institutions and agencies of New Jersey.

Sister Kenny Incurs Wrath of Orthopedic Surgeons

Sister Kenny has been accused of making untrue statements, of quoting statistics inaccurately and of making unjustified attacks upon some methods of treatment for poliomyelitis which are of definite value in certain types of cases.

The accusations appear in a report by a group of professors representing the A.M.A., the American Academy of Orthopedic Surgeons and the American Orthopedic Association.

The rigid technic insisted upon by Miss Kenny in the application of hot packs is neither important nor essential, this committee declares. Splints, braces and respirators are important for certain cases at the time they are needed, it affirms.

"Miss Kenny has repeatedly stated that under 'orthodox' treatment only 13 per cent of the patients recovered without paralysis, while under her treatment more than 80 per cent recover. We believe this is a deliberate misrepresentation of the facts of treatment by other methods. This we attribute to her overzealous desire to promote further the adoption of the Kenny treatment," the report declares.

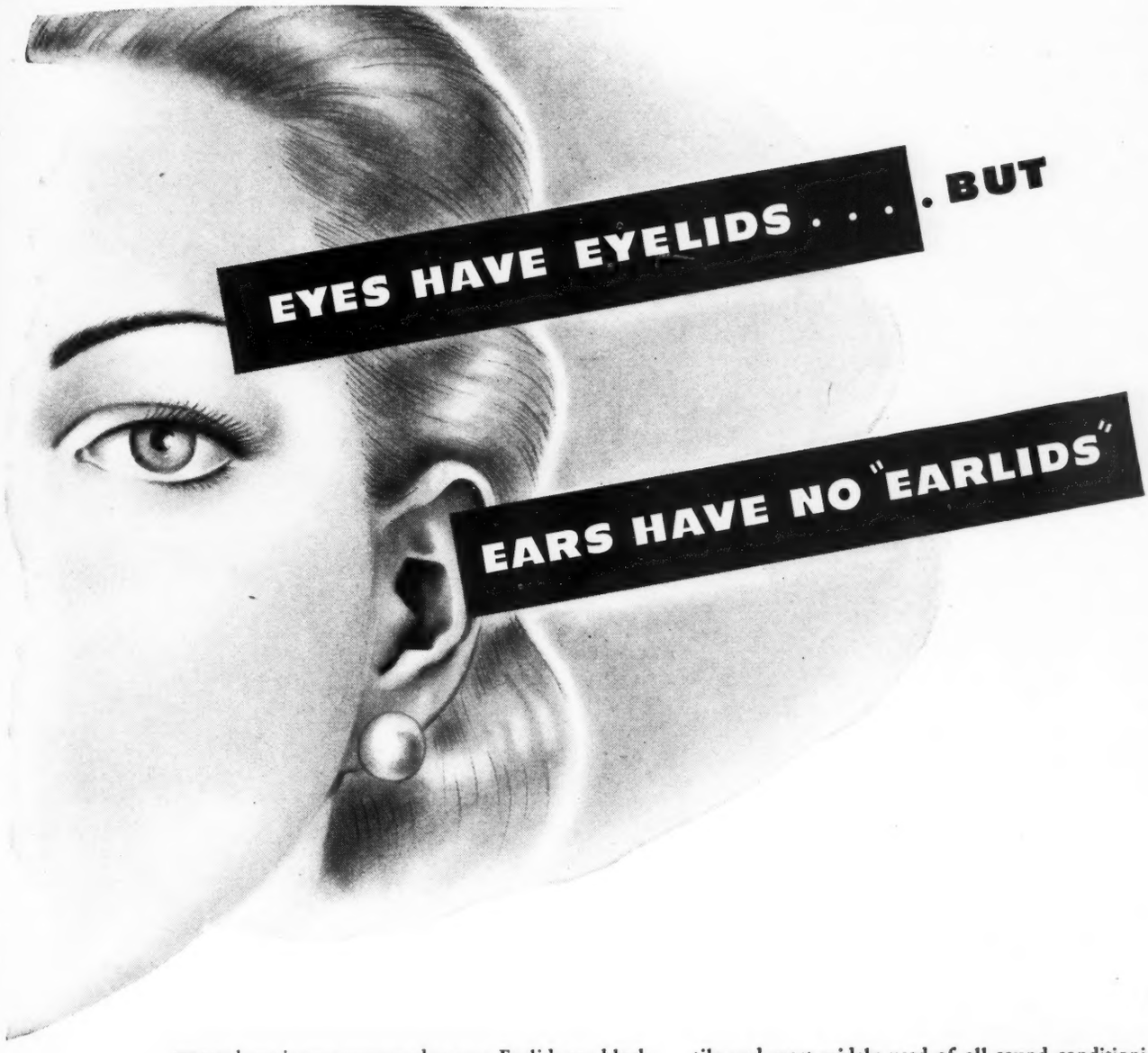
The committee stated in conclusion that the publicity has stimulated the medical profession to reevaluate known methods of treatment of this disease and to treat it more effectively.

Sunbury Goes Over the Top

"Over the top" by more than $100,000 was the result of the financial campaign for $225,000 in cash and pledges for Sunbury Community Hospital, Sunbury, Pa., which ended in June. About $75,000 of the total of $343,000 subscribed was in cash. The money will be used to construct a new modern hospital building to contain 150 beds and 30 bassinets. Construction of the new building may not begin until late in 1944 or early 1945. A. L. Mitke is the hospital superintendent. Ketchum, Inc., of Pittsburgh, directed the campaign.

Penicillin Included

On the day that penicillin was released for civilian use, Group Hospital Service of St. Louis notified all member hospitals of the plan that the drug was to be provided to Blue Cross members at no additional cost, it was reported at the eighth annual meeting of the plan. At this meeting approval was given to the action of the trustees in extending cooperation to the medical profession of Missouri in coordinating management activities of the new medical-surgical plan with those of the Blue Cross. The plans will be managed jointly but will be financially independent of each other.



EYES have it easy compared to ears. Eyelids can block out irritating light. But ears have no "earlids." They have to take noise every minute. And to a sick and nervous patient even the slightest noise can become a serious irritation.

Conditions in hospitals today have spotlighted noise as a troublemaker. Overcrowding . . . inexperienced help and increased activity have brought higher noise levels to every floor. This harasses the patients and retards recoveries. It makes the work of depleted staffs more difficult and tiring.

Fortunately there's an easy way to mute today's hospital noises into soothing quiet that works magic with nervous patients and jittery staffs. Follow the example of leading hospitals by Sound Conditioning with Acousti-Celotex*. This is the famous perforated fibre tile and most widely used of all sound conditioning materials. It can be applied quickly and quietly without disturbance. It can be painted without loss of efficiency.

Do this: try Acousti-Celotex* in one noisy area, a corridor, ward or diet kitchen. *Hear* the difference it makes—and can make with all your other noise problems.

Call the Acousti-Celotex* distributor in your town. He is sound conditioning headquarters and a member of the world's most experienced acoustical organization. His advice is yours without obligation, and he *guarantees* results. If you can't locate him, a note to us will bring him to your desk.

FREE! Informative, illustrated booklet, "The Quiet Hospital." Reading time, 8 minutes. Mail coupon for your copy, today.

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Labor Union Seeks to Tax Seattle Voluntary Hospitals

A Seattle labor union is trying to put all voluntary hospitals in the state on the tax rolls, according to the June news letter of the Washington State Hospital Association. "Voluntary hospital authorities should get into action at once, with their directors and legal counsel alert to the seriousness of the current situation," states Howard C. Ries, president of the association.

"The assessor of King County has inspected the accounts of Seattle hospitals and, because some hospitals show no receipts of gifts and charitable donations, they have been placed on the tax rolls for real and personal property taxes."

Mr. Ries suggests that hospitals organize at once an association of lay people who will solicit donations for the hospital to be used for the care of indigent patients.

Nursing School 50 Years Old

The school of nursing of Muhlenberg Hospital, Plainfield, N. J., celebrated its fiftieth anniversary in June. The school had three students in 1894 and 112 in 1944. A supper to the present graduating class by the alumnae association and a pageant of the history of nursing from 300 A.D. to the present were features of the celebration.

Postwar Construction for St. Louis

Plans for hospital development costing between $5,200,000 and $5,700,000 for rehabilitation of St. Louis municipal hospitals and construction of new institutions were announced in May by Dr. Francis M. Grogan, hospital commissioner. The major item in the program is a new chronic disease hospital to cost from $2,500,000 to $3,000,000 and to hold 1000 beds.

Urges Extension of Hospitals

Extension of the facilities of established hospitals so that they may care for war wounded instead of construction of a new military hospital was proposed in Montreal by Sen. L. A. David in his president's address at the annual meeting of St. Luke's Hospital. Under this plan, the investment could be used to advantage in postwar years after the needs of military casualties had been met, he declared. Established hospitals, Senator David said, are profiting by the experience of competent administration and should be given the opportunity of assuring permanence to their work.

New Association Headquarters

The American Physiotherapy Association has established its offices at 1790 Broadway, New York 19. Mrs. Evelyn Anderson May is the executive secretary.

Twelfth A.C.H.A. Institute Will be Held in September

The twelfth Chicago institute for hospital administrators will be conducted at International House on the University of Chicago campus from September 11 to 22 by the American College of Hospital Administrators. It will be under the direction of Dr. Malcolm T. MacEachern as in previous years.

Administrators and assistant administrators are eligible for enrollment in the institute. Special emphasis this year will be put on the problems of hospital finance.

Information and enrollment forms may be obtained from the A.C.H.A., 18 E. Division Street, Chicago.

Booklet Tells Butler Story

A handsome 50 page book, entitled "A Century of Butler Hospital, 1844-1944," was published last month by this hospital of Providence, R. I. In addition to a foreword by the president, it includes "A Layman's Narrative" by William Greene Roelker, director of the Rhode Island Historical Society, "The Achievements of Five Superintendents" by Dr. Arthur H. Ruggles, present superintendent, and "The Closing of a Century" by Dr. Gregory Zilboorg, associate editor, centenary volume of the American Psychiatric Association.

A gambler f. c. is the Tartar,
But in trading you'll find no one smarter.
Without facts, he won't budge.
He just sighs, "I'm the judge.
Give the evidence, sir — or no barter!"

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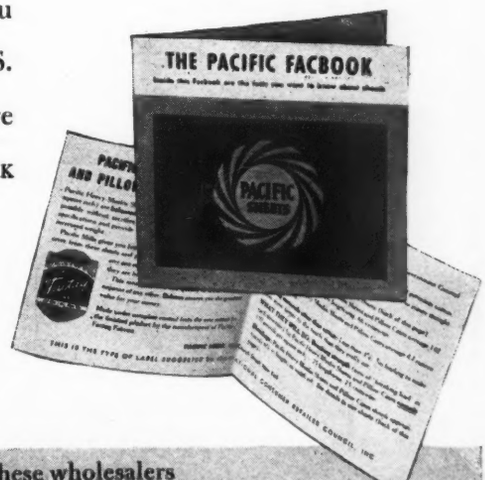

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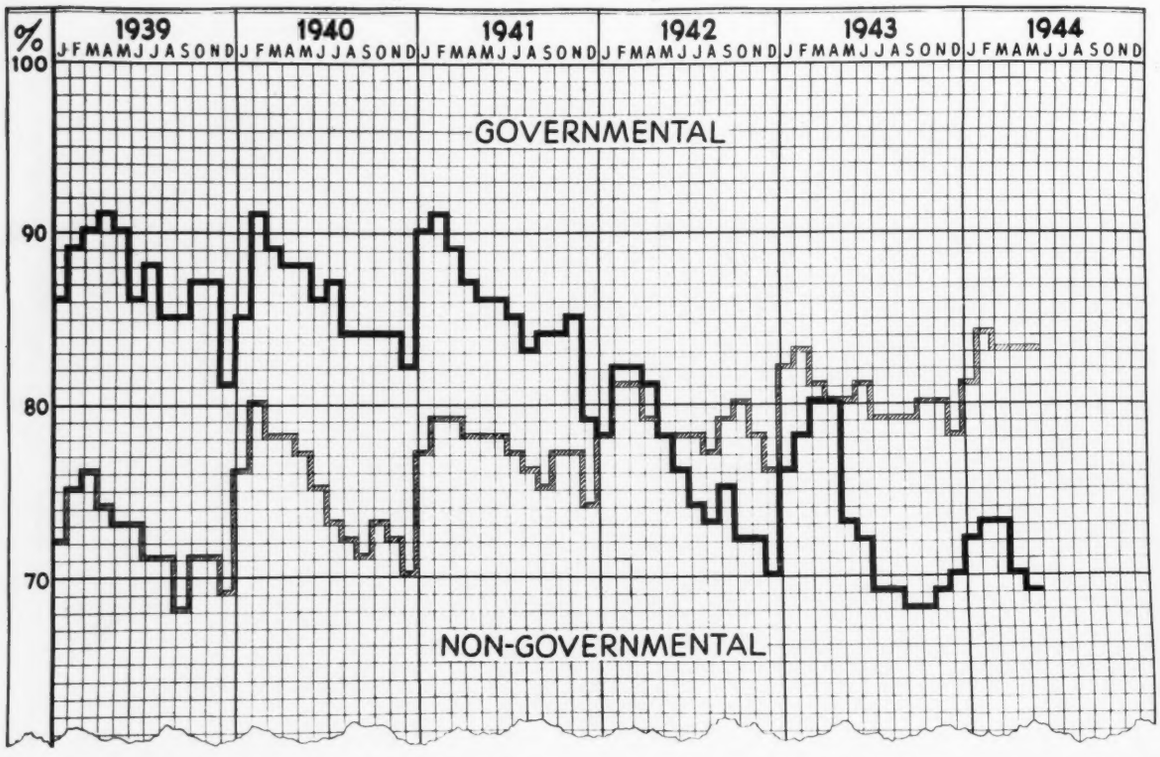
May Was a Busy Month, Too



Occupancy in nongovernmental general hospitals continued at a high rate in May, according to preliminary reports. In the governmental general hospitals, however, occupancy fell off one per cent, *i.e.* from 70 per cent in April to 69 per cent in May.

Hospital construction announced for the period from May 15 to June 12 included 55 projects of which 51 gave costs of $7,104,000. This brought the total construction from the first of the year to $46,805,000 as compared with $56,171,000 for the same period of last year (excluding postponed projects).